J. Provider Explanation of Payment (EOP) Codes

Section J.1 and J.2 lists codes that may appear on a Provider Explanation of Payments (EOP) for paid, denied, or adjusted claims.

Section J.3 lists the upfront error messages. The Provider Electronic Solutions (PES) software performs up-front edits before claims go into the system. PES assigns an error message to each rejected claim, which providers may then correct and resubmit into the system.

J.1 Claim Adjustment Reason Code/Remittance Advice Remark Codes

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**447**	Daily management of an epidural or subarachnoid catheter may not be billed on the same day as a procedure for catheter placement.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**449**	Physician visit codes/primary anesthesia codes may not be billed within 3 days or on the same day of each other.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N123**	This is a split service and represents a portion of the units from the originally submitted service.	**737**	Units on this claim have been systematically reduced to meet the benefit limit.
B5	Payment adjusted because coverage/program, guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**70**	Encounter rate procedures and fee-for-service procedures cannot be billed on the same claim. Split bill.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**669**	Services cannot be billed on the same day for the same recipient.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**M50**	Missing/Incomplete/ invalid revenue code(s).	**10**	Emergency facility procedure codes may be billed with revenue code 450 only.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			**13**	Revenue codes 172, 175 or 179 cannot be billed in conjunction with a normal newborn diagnosis (v30).
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**18**	Home health providers cannot bill inpatient and outpatient services on the same claim.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			**19**	HIV codes must be billed in conjunction with family planning codes z5181-z5183 or z5190.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			**20**	Family planning procedure z5190 must be billed with z5195.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**21**	Outpatient physical therapy cannot be billed in conjunction with any other service.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			**25**	Unborn recipient's Medicaid number should be used only for infant services.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**M77**	Missing/Incomplete/ invalid place of service.	**26**	EPSDT-referred therapy services are restricted to place of service "11" or "99".
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**M50**	Missing/incomplete/ invalid revenue code(s).	**33**	Revenue codes 170 - 171 are valid for the mother's number. Revenue codes 172, 175 or 179 are valid for the baby's number. (invalid revenue code for recipient age).
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			**37**	Revenue codes 170 -171 must not exceed 10 units under mother's number. (nursery days invalid)
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**57**	Ten units of code Z5294 must be billed prior to any units of Z5295.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider	**58**	Service for maternity waiver/care recipient must be

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
			information.		billed with global service fee.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**61**	Injectable and non-injectable procedures cannot be billed together.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**62**	FQHC services billed at pos-21 (inpatient hospitals) cannot be billed on the same claim with other FQHC services.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			**79**	Procedure code not valid for renal dialysis facility.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**MA31**	Missing/incomplete/invalid beginning and ending dates of the period billed.	**90**	Global delivery procedure code cannot be span dated. Use date of delivery.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**M50**	Missing/incomplete/invalid revenue code(s).	**97**	Procedure and revenue code combination not valid.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			**102**	Service(s) past the maximum Medicaid filing limit.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**103**	Therapy code payable only with therapeutic treatment.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**104**	Procedure codes 99281-99285 and 99291 can only be billed once on a claim.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**109**	Observation must be billed in conjunction with facility fee.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N39**	Procedure code is not compatible with tooth number/letter.	**127**	Pulp therapy not allowed for this tooth number/letter.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**130**	Invalid claim type for plan first program.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**178**	Procedure must be billed with chemotherapy.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N24**	Missing/incomplete/invalid electronic funds transfer (EFT) banking information.	**358**	PHP providers must have a current EFT segment.

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B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			**451**	This schedule II drug is not refillable.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			**529**	Ten units of code Z5294 must be billed prior to any units of Z5295.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			**552**	Procedure code not covered when billed on the same day.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**600**	Pulp therapy combination not allowed in this case.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**601**	Pulp therapy combination not allowed in this case
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**602**	Pulp therapy combination not allowed in this case.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**603**	Pulp therapy combination not allowed in this case.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**604**	Pulp therapy combination not allowed in this case.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**605**	Pulp therapy combination not allowed in this case.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**606**	Pulp therapy combination not allowed in this case.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**607**	Pulp therapy combination not allowed.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**608**	Pulp therapy combination not allowed.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**609**	Pulp therapy combination not allowed.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**610**	Pulp therapy combination not allowed.

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B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**613**	Pulp therapy combination not allowed.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**621**	Pulp cap not allowed for this tooth/date of service.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			**624**	Procedure code (Z5181) will not be paid on the same date of service as (Z5182-Z5184) for the same recipient.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded			**625**	Post-cataract follow-up care has been paid to the surgeon or post-cataract follow-up care cannot be paid until the surgeon has been paid. Contact the surgeon.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			**626**	Procedure code not covered when billed on the same day.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			**627**	Procedure code not covered when billed on the same day.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**629**	Comprehensive EPSDT screening and FP visit may not be billed on the same day.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			**638**	More than one encounter code cannot be billed on same date of service without justification - excluding dental.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**663**	Procedure codes 92553, 92556 and 92557 cannot be billed on the same day by the same or different provider
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**665**	Services cannot be billed on the same day by the same provider.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**666**	Service cannot be billed on the same day by the same provider.
B5	Payment adjusted because coverage/program guidelines were not met or	**N20**	Service not payable with other service rendered on the same	**667**	Services cannot be billed on the same day by the

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
	were exceeded.		date.		same provider.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**674**	Services cannot be billed on the same day for the same recipient.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**676**	Procedure cannot be billed on the same day as critical care.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**677**	Services cannot be billed on the same day for the same recipient.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**678**	Services cannot be billed on the same day by the same provider.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**679**	Services cannot be billed on the same day for the same recipient
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**680**	Services cannot be billed on the same day by the same provider.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**682**	This service is not allowed on the same day as day treatment
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded	**N20**	Service not payable with other service rendered on the same date.	**685**	Services cannot be billed on the same day by the same provider.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**687**	Clinic codes z5145-z5149 cannot be billed on the same day with same unique number as 99241-99245 and 99281-99285.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**694**	Procedure code not covered when billed on the same day.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N39**	Procedure adjusted because coverage/program guidelines were not met or were exceeded.	**703**	Core buildup not covered with other restoration.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N39**	Procedure adjusted because coverage/program guidelines were not met or were exceeded.	**704**	Two restorations not covered for the same tooth number.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**705**	Two restorations not covered for the same tooth number, same date of service.

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B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**751**	Family planning visit not payable after sterilization.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N59**	Please refer to your provider manual for additional program and provider information.	**766**	Crowns are not payable when billed without a paid root canal for the same tooth number.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**773**	Procedure codes 95115, 95117 or z4998 shall not be paid on the same day as procedure codes 95120 - 95134.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**774**	Procedure codes 95120-95134 will not be paid on the same day as procedure codes 95135-95170.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**775**	Procedure code not allowed on the same day (95115 and 95117).
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**776**	Procedure codes not allowed on the same day (95130- 95134).
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**777**	Procedure not covered when billed with procedure codes 90918-90947.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**779**	Procedure code cannot be billed on the same day with procedure codes z5181-z5185.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**781**	Prenatal visit not be covered on the same day as postpartum visit.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**782**	Prenatal visit not covered for the same date of service of family planning.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**784**	Procedure not covered when billed with 76805, 76810 or 76816 on the same day.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**785**	Procedure not covered when billed with 76805 on the same day.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**786**	Procedure cannot be billed on the same day as critical care.

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B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**791**	The same physician may not bill intubation and newborn resuscitation on the same day.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**794**	Standby/ resuscitation/ attendance at delivery cannot be billed together.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**796**	Procedure code not covered when billed on the same day.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**803**	Procedure cannot be billed on the same day by the provider.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**812**	Chemistry profile and chemical panel cannot be billed on the same day.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**815**	Electroshock therapy may not be on the same day as a hospital visit.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**818**	Multiple urinalysis tests cannot be billed on the same day.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**824**	Salpingectomy will not be paid on the same day as a tubal ligation.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**831**	Components of a cbc may not be billed on the same day as a complete cbc
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**839**	Professional components and hospital visits may not be billed on the same day.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**840**	Components of a cbc may not be billed on the same day as a complete cbc
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**845**	EPSDT vision screen and external ocular photography not covered on the same day.

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B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**846**	Prevocational services and supported employment shall not be paid on the same day.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			**847**	More than three office visits may not be billed with pregnancy diagnosis.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**857**	Components of a CBC may not be billed on the same day as a complete CBC.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**858**	Components of a urinalysis may not be billed on the same day as urinalysis.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**860**	Screening provider may not bill for screening exam and inclusive medical services on the same day.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**866**	Components of a CBC may not be billed on the same day as a complete CBC.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**870**	The same provider may not bill hospital visits/ psychotherapy on the same day.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**871**	The same provider may not bill psychotherapy/office visits on the same day
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			**872**	Procedure is limited to one service at the time of or within thirty days prior to Norplant insertion
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**882**	Components of a CBC may not be billed on the same day as a complete CBC.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			**883**	Subsequent critical care not valid without initial care.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			**893**	More than one obstetrical delivery code may not be billed within six

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					months.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**N20**	Service not payable with other service rendered on the same date.	**897**	Outpatient chemotherapy and emergency department service codes may not be billed on the same day.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			**906**	This schedule II drug is not refillable.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	**M97**	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.	**927**	OTC drug not covered for LTC recipients.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.			**952**	Previously alerted claim cannot be overridden.
B6	This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty. This code will be deactivated on 2/1/2006. Replaced with ARC 172.			**189**	Diagnosis invalid for provider specialty.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.			**218**	Performing provider identified for purge. Call EDS at 1(888) 223-3630 to update your records.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	**MA120**	Missing/incomplete/invalid CLIA certification number.	**88**	Clia number not on file/invalid or provider not authorized to bill procedure code.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.			**112**	There is no provider number for long term care file for this recipient.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.			**146**	Procedure/revenue code is inappropriate for this provider type.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service			**154**	Procedure code is not covered for this provider specialty.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.			**155**	Procedure/revenue code is invalid for claim type.
B7	This provider was not certified/eligible to be paid for this procedure/service on			**156**	Procedure code is on review for the provider.

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	this date of service.				
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.			**219**	Billing provider identified for purge. Call EDS at 1(888)223-3630 to update your records.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.			**224**	Enrollment file indicates that this provider number is not valid for these dates of service
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.			**228**	Dates of service are not within approved provider enrollment period.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.			**237**	The performing provider number is not on file.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.			**270**	This recipient is not listed on the long term care (LTC) file for dos indicated.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.			**272**	Provider does not match provider on LTC file for this recipient.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.			**276**	Recipient is not eligible for waivered services according to the LTC file.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	**N20**	Service not payable with other service rendered on the same date.	**668**	Services cannot be billed on the same day by the same provider
B12	Services not documented in patients' medical record.			**965**	This claim has been adjusted to make changes to the dates of service.
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.			**504**	The claim or service was previously paid on date indicated.
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.			**521**	This claim or service was previously paid on date indicated.
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	**M86**	Service denied because payment already made for similar procedure within set time frame.	**524**	The payment for this service was previously made to another provider or to another number for the same provider.

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B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	**M86**	Service denied because payment already made for similar procedure within set time frame.	**528**	This claim or service was previously paid on date indicated.
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	**M86**	Service denied because payment already made for similar procedure within set time frame.	**547**	This claim or service was previously paid on date indicated.
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	**M86**	Service denied because payment already made for similar procedure within set time frame.	**549**	This claim or service was previously paid on date indicated.
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	**M86**	Service denied because payment already made for similar procedure within set time frame.	**848**	The payment for this service was previously made to another provider or to another number for this provider.
B14	Payment denied because only one visit or consultation per physician per day is covered.			**688**	Dental encounter (09430) limit one per day, per recipient, per provider
B14	Payment denied because only one visit or consultation per physician per day is covered.			**689**	Only one hospital admission may be billed per hospital stay.
B14	Payment denied because only one visit or consultation per physician per day is covered.			**711**	Individual therapy and group therapy may not be billed on the same day.
B14	Payment denied because only one visit or consultation per physician per day is covered.	**N20**	Service not payable with other service rendered on the same date.	**778**	Only one outpatient observation visit may be billed per day.
B14	Payment denied because only one visit or consultation per physician per day is covered.	**N20**	Service not payable with other service rendered on the same date.	**833**	Emergency room visit/initial hospital visit may not be billed on the same day.
B14	Payment denied because only one visit or consultation per physician per day is covered.	**N20**	Service not payable with other service rendered on the same date.	**855**	The same physician may not bill hospital visit and discharge visit on the same day.
B14	Payment denied because only one visit or consultation per physician per day is covered.	**N20**	Service not payable with other service rendered on the same date.	**867**	Subsequent hospital care may not be billed on same day as initial hospital care.
B14	Payment denied because only one visit or consultation per physician per day is covered.			**878**	Physician is limited to one visit per day per recipient.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
B14	Payment denied because only one visit or consultation per physician per day is covered.	**N20**	Service not payable with other service rendered on the same date.	**885**	Hospital visits and subsequent critical care may not be billed on the same day.
B15	Payment adjusted because this procedure/service is not paid separately.	**N59**	Please refer to your provider manual for additional program and provider information.	**635**	When prophylaxis and fluoride are billed on the same day, the combined code must be billed.
B15	Payment adjusted because this procedure/service is not paid separately.	**N59**	Please refer to your provider manual for additional program and provider information.	**636**	When prophylaxis and fluoride are billed on the same day, the combined code must be billed. Request recoupment of previous paid claim before filing combined code.
B18	Payment adjusted because this procedure code and modifier were invalid on the date of service.	**N56**	Procedure code billed is not correct/valid for the services billed or the date of service billed.	**326**	Injectable is currently on the list.
B18	Payment adjusted because this procedure code and modifier were invalid on the date of service.	**M78**	To be deactivated 5/18/2006.	**27**	The modifier may only be billed on Medicare-related claims.
B18	Payment adjusted because this procedure code and modifier were invalid on the date of service.	**M78**	To be deactivated 5/18/2006.	**32**	Modifier not effective for this date of service.
B18	Payment adjusted because this procedure code and modifier were invalid on the date of service.	**M78**	To be deactivated 5/18/2006.	**34**	Cataract services require proper modifier to be billed.
B18	Payment adjusted because this procedure code and modifier were invalid on the date of service.			**290**	Dos billed is prior to program begin date.
B18	Payment adjusted because this procedure code and modifier were invalid on the date of service.			**355**	Procedure code missing/invalid or the modifier invalid.
B18	Payment adjusted because this procedure code and modifier were invalid on the date of service.	**M78**	To be deactivated 5/18/2006.	**438**	Hearing and vision screenings require EP modifier.
B20	Payment adjusted because procedure/service was partially or fully furnished by another provider.	**N10**	Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor	**957**	This payment has been recouped to enable payment to the correct provider.
D21	This (these) diagnosis (es) is (are) missing or are invalid.	**M64**	Missing/incomplete/ invalid other diagnosis.	**192**	The third diagnosis code is invalid.

Deleted from 27, 32, 34, and 438: ~~Missing/ incomplete/ invalid HCPCS modifier.~~

Added to 27, 32, 34 and 438: To be deactivated 5/18/2006.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
D21	This (these) diagnosis(es) is (are) missing or are invalid.	**M64**	Missing/incomplete/ invalid other diagnosis.	**193**	Fourth diagnosis code is invalid.
D21	This (these) diagnosis(es) is (are) missing or are invalid.	**M81**	You are required to code to the highest level of specificity.	**198**	Primary diagnosis code must be billed at highest subdivision.
D21	This (these) diagnosis(es) is (are) missing or are invalid.	**M64**	Missing/incomplete/ invalid other diagnosis.	**199**	Other diagnosis code must be billed at highest subdivision.
D21	This (these) diagnosis(es) is (are) missing or are invalid.	**M65**	Missing/incomplete/ invalid admitting diagnosis.	**313**	Admitting diagnosis is missing, invalid or not on file.
1	Deductible amount			**961**	This claim has been adjusted to reflect a change in coinsurance and/or deductible.
2	Coinsurance Amount	**N58**	Missing/incomplete/ Invalid patient liability amount.	**47**	The coinsurance amount is invalid.
2	Coinsurance Amount	**MA34**	Missing/incomplete/ invalid number of coinsurance days during the billing period.	**94**	Coinsurance days billed are missing or invalid.
3	Co-payment Amount			**361**	Payment has been reduced or denied due to the application of copay.
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.			**14**	This service requires an appropriate modifier.
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	**M78**	To be deactivated 5/18/2006.	**60**	Maternity waiver service modifier not billed correctly
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	**M78**	To be deactivated 5/18/2006.	**145**	Modifier is invalid.
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	**M78**	To be deactivated 5/18/2006.	**147**	Invalid modifier for procedure.
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.			**283**	Modifier billed is not valid for the procedure code billed.
4	The procedure code billed is inconsistent with the modifier used or a required modifier is missing.	**M78**	To be deactivated 5/18/2006.	**359**	Bill the appropriate laparoscopic code w/modifier 22.
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.			**980**	Claim adjusted to add/delete modifier.
5	The procedure code/bill type is inconsistent with the place	**MA30**	Missing/incomplete/ invalid type of bill.	**29**	Type of bill is invalid.

Deleted from 60, 145, 147, and 359: ~~Missing/ incomplete/ invalid HCPCS modifier.~~

Added to 60, 145, 147, and 359: To be deactivated 5/18/2006.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
	of service.				
5	The procedure code/bill type is inconsistent with the place of service.	**M77**	Missing/incomplete/invalid place of service.	**71**	Invalid place of service for FQHC provider
5	The procedure code/bill type is inconsistent with the place of service.			**81**	Procedure cannot be billed with a non-patient visit (type of bill 141).
5	The procedure code/bill type is inconsistent with the place of service.			**113**	The procedure code is not covered when provided by an ambulatory surgical center.
5	The procedure code/bill type is inconsistent with the place of service.	**M77**	Missing/Incomplete/ invalid place of service.	**136**	Place of service is invalid.
5	The procedure code/bill type is inconsistent with the place of service.	**M77**	Missing/incomplete/ invalid place of service.	**148**	Place of service code is invalid for procedure.
5	The procedure code/bill type is inconsistent with the place of service.			**185**	Procedure not covered at POS for provider.
5	The procedure code/bill type is inconsistent with the place of service.			**285**	Procedure billed not covered for FQHC facility
5	The procedure code/bill type is inconsistent with the place of service.			**292**	This type of service and/or procedure code is invalid for a radiology facility.
6	The procedure/revenue code is inconsistent with the patient's age.			**42**	EPSDT referred services are restricted to recipients under 21 on the date of service.
6	The procedure/revenue code is inconsistent with the patient's age.			**114**	Service non-payable for recipient less than six months of age.
6	The procedure/revenue code is inconsistent with the patient's age.			**149**	Procedure/revenue code/NCD is not covered for recipient's age.
6	The procedure/revenue code is inconsistent with the patient's age.			**184**	Service not covered for recipient age.
6	The procedure/revenue code is inconsistent with the patient's age.	**N30**	Recipient ineligible for this service.	**264**	Service is not covered for recipient under 65 years of age.
6	The procedure/revenue code is inconsistent with the patient's age.			**265**	Recipient must be 21 years of age or younger as of admission date shown in fl 15.
8	The procedure code is inconsistent with the provider type/specialty (taxonomy).			**64**	Invalid procedure for FQHC crossover claims.
9	The diagnosis is inconsistent with the patient's age.			**194**	Primary diagnosis is invalid for

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
					recipient of this age.
9	The diagnosis is inconsistent with the patient's age.	**M64**	Missing/incomplete/invalid other diagnosis.	**195**	Other diagnosis code is invalid for recipient's age.
9	The diagnosis is inconsistent with the patient's age.			**207**	The detail diagnosis code is invalid for recipient's age.
10	The diagnosis is inconsistent with the patient's gender.			**150**	This service is not reimbursable for a recipient of this sex.
10	The diagnosis is inconsistent with the patient's gender.	**MA63**	Missing/incomplete/ invalid principal diagnosis.	**196**	Primary diagnosis is invalid for recipient's sex.
10	The diagnosis is inconsistent with the patient's gender.	**M64**	Missing/incomplete/ invalid other diagnosis.	**197**	Other diagnosis code is invalid for recipient's sex.
10	The diagnosis is inconsistent with the patient's gender.			**206**	The detail diagnosis is invalid for the recipient's sex.
11	The diagnosis is inconsistent with the procedure.	**M64**	Missing/incomplete/ invalid other diagnosis.	**153**	Diagnosis is inappropriate for the procedure being billed.
12	The diagnosis is inconsistent with the provider type.			**15**	The diagnosis code is not valid for transportation providers.
14	The date of birth follows the date of service.			**183**	Date of service is prior to recipient's date of birth
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	**M62**	Missing/incomplete/ invalid treatment authorization code.	**23**	Organ transplants (except kidney or cornea) require prior authorization. Contact Alabama Medicaid.
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider. .	**M62**	Missing/incomplete/ invalid treatment authorization code.	**67**	Ultrasound for maternity waiver/care recipient requires a pa
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	**N59**	Please refer to your provider manual for additional program and provider information.	**386**	Invalid PA detail – New request may not be submitted with other request types.
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	**N54**	Claim information is inconsistent with precertified/authorized services.	**387**	Incomplete PA detail – Must contain either units or dollars.
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the	**M62**	Missing/incomplete/ invalid treatment authorization code.	**389**	Claim was denied because EDS had no record of the

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
	billed services or provider.				prior authorization.
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.			**390**	Provider number on claim does not match provider number on pa file.
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.			**397**	Prior authorization number shown on the claim is invalid.
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.			**399**	Service requires pa.
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	**M62**	Missing/incomplete/invalid treatment authorization code.	**827**	Code, service, procedure, NCD or stay requires prior authorization
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	**M53**	Missing/incomplete/ Invalid days or units of service.	**30**	Unit(s) billed is missing or invalid.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	**M50** **M54**	Missing/ incomplete/ invalid revenue code(s). Missing/ incomplete/ invalid total charges.	**164**	Accommodation revenue code is not present on inpatient claim or claim denied because covered charges for days billed equal non-covered charges.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	**MA92**	Missing/incomplete/invalid plan information for other insurance.	**173**	TPL policy number and insurance company name required.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	**M45**	Missing/incomplete/ invalid occurrence code(s).	**174**	Accident indicator occurrence code required.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.	**N258**	Missing/incomplete/ invalid billing provider/supplier address.	**222**	Provider's address is invalid. Contact EDS's provider enrollment unit.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**251**	Recipient has an unusable record. Contact EDS.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**506**	Claims adjusted by Medicare must be submitted to EDS adjustment unit with proper documentation.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.			**902**	Medicaid billing authorization form (XIX-TPD-1 - 76) is required for this claim.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.			**931**	Missing/invalid service provider ID qualifier.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.			**932**	Missing/invalid insurance segment.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.			**933**	Missing/invalid claim segment.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.			**934**	Product/service not covered.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.			**935**	Missing/invalid product/service ID qualifier.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.			**936**	Missing/invalid prescriber segment.
16	Claim/service lacks information which is needed for adjudication. Additional			**937**	Missing/invalid prescriber ID qualifier.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
	information is supplied using remittance advice remarks codes whenever appropriate.				
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.			**938**	Missing/invalid pricing segment.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.			**939**	Missing/invalid other payer amount paid qualifier.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.			**940**	Non-matched NDC number on reversal TXN.
17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N59**	Please refer to your provider manual for additional program and provider information.	**179**	Sterilization denied because documentation does not meet hhs/Medicaid requirements.
17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N59**	Please refer to your provider manual for additional program and provider information.	**180**	Hysterectomy denied because documentation does not meet hhs/Medicaid requirements.
17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N59**	Please refer to your provider manual for additional program and provider information.	**181**	Abortion denied because documentation does not meet HHS/Medicaid requirements.
17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N59**	Please refer to your provider manual for additional program and provider information.	**182**	No consent form on file for recipient and date of surgery.
17	Payment adjusted because requested information was not provided or was insufficient/incomplete.			**267**	Census data is not on file for provider for the previous month.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
	Additional information is supplied using the remittance advice remarks codes whenever appropriate.				
18	Duplicate claim/service.			**490**	Exact duplicate of another pharmacy claim.
18	Duplicate claim/service.			**491**	Suspect duplicate of another pharmacy claim.
18	Duplicate claim/service.			**493**	Duplicate RX code for same date of service.
18	Duplicate claim/service.			**501**	Our records show this service has already been paid for the date of service billed.
18	Duplicate claim/service.			**502**	This claim or service was previously paid on date indicated.
18	Duplicate claim/service.	**M86**	Service denied because payment already made for same/similar procedure within set time frame.	**503**	Procedure codes cannot be billed more than six (6) times with the same modifier.
18	Duplicate claim/service.			**505**	Our records show this service for the date of service billed is a duplicate.
18	Duplicate claim/service.			**511**	Our records show this service for the date(s) of service billed is a duplicate.
18	Duplicate claim/service.			**512**	This claim or service was previously paid on date indicated
18	Duplicate claim/service.			**513**	Our records show this service for the date(s) of service billed is a duplicate.
18	Duplicate claim/service.			**515**	Our records show this service for the date(s) of service billed is a duplicate.
18	Duplicate claim/service.			**520**	Service previously billed, the original claim is currently in process.
18	Duplicate claim/service.			**523**	Prior claim with this prescription/refill number is in process.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
18	Duplicate claim/service.			**527**	Service previously billed, the original claim is currently in process.
18	Duplicate claim/service.			**531**	Our records show this service for the date(s) of service billed is a duplicate.
18	Duplicate claim/service.			**532**	Our records show this service for the date(s) of service billed is a duplicate.
18	Duplicate claim/service.			**533**	Service previously billed, the original claim is currently in process.
18	Duplicate claim/service.			**535**	Our records show this service for the date(s) of service billed is a duplicate.
18	Duplicate claim/service.			**538**	A cardiologist or a radiologist cannot bill this procedure code on the same day
18	Duplicate claim/service.			**542**	Procedure code not covered when billed on the same day.
18	Duplicate claim/service.			**543**	Service previously billed, the original claim is currently in process.
18	Duplicate claim/service.			**544**	Our records show this service for the date(s) of service billed is a duplicate.
18	Duplicate claim/service.			**628**	EPSDT visit has been paid for this recipient for the same date of service.
18	Duplicate claim/service.			**632**	Only one type of respite care is allowed for a given date of service.
18	Duplicate claim/service.	**N20**	Service not payable with other service rendered on the same date.	**633**	Residential services and respite care not allowed for the same dos
18	Duplicate claim/service.			**738**	Our records indicate that this service has already been performed on this patient.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
18	Duplicate claim/service.			**828**	Our records indicate that this service has already been performed on this recipient.
18	Duplicate claim/service.			**834**	Our records indicate that this service has already been performed on this patient.
18	Duplicate claim/service.			**835**	Our records indicate that this service has already been performed on this patient.
18	Duplicate claim/service.			**841**	Our records indicate that this service has already been performed on this patient.
18	Duplicate claim/service.			**970**	This claim has been recouped/adjusted due to a duplicate payment.
22	Payment adjusted because this care may be covered by another payer per coordination of benefits.			**176**	Third party file indicates Medicare comprehensive insurance for recipient.
22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	**N30**	Recipient ineligible for this service.	**248**	Eligible for Medicare only - no Medicaid benefits.
22	Payment adjusted because this care may be covered by another payer per coordination of benefits.			**280**	Recipient has other medical coverage; file third party carrier first.
22	Payment adjusted because this care may be covered by another payer per coordination of benefits.			**282**	Recipient has Medicare coverage - bill Medicare first.
22	Payment adjusted because this care may be covered by another payer per coordination of benefits.			**991**	Recipient has become retroactively eligible for Medicare for billed dates of service billed. File Medicare.
23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments.			**68**	This service was covered in full by Medicare.
23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments.			**362**	Copay and Medicare and other third party payments have reduced/denied payment.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments.			**364**	Medicaid allowed amount reduced by other insurance amount.
23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments.			**366**	Other insurance paid an amount greater than or equal to our allowed amount. Medicaid cannot make any additional payment.
23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments.			**369**	This service was covered in full by Medicare.
23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments.			**960**	This claim has been adjusted to reflect payment by other insurance.
24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.			**279**	Claim denied. Recipient has Medicare HMO coverage.
26	Expenses incurred prior to coverage.	**N30**	Recipient ineligible for this service.	**254**	Records show this recipient is totally ineligible for Medicaid for header date(s) of service.
26	Expenses incurred prior to coverage.	**N30**	Recipient ineligible for this service.	**262**	Records show this recipient is totally ineligible for Medicaid for detail date(s) of service.
29	The time limit for filing has expired.			**8**	Service(s) past the maximum Medicaid filing limit.
30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements. This code will be deactivated on 2/1/2006. Replaced with ARC 177.			**429**	Recipient eligibility determination is being made. Please do not rebill.
31	Claim denied as patient cannot be identified as our insured.			**250**	The recipient's 13-digit Medicaid number is missing or invalid.
31	Claim denied as patient cannot be identified as our insured.			**256**	The recipient's 13-digit Medicaid number is missing or invalid.
38	Services not provided or authorized by designated (network/primary care) providers.			**107**	Recipient enrolled in the patient 1st program; services require

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
					referral from PMP.
38	Services not provided or authorized by designated (network/primary care) providers.			**131**	Service is only covered under the plan first. Program.
38	Services not provided or authorized by designated (network/primary care) providers.			**132**	Birth control pills must be received from a physician for the plan first program.
38	Services not provided or authorized by designated (network/primary care) providers.			**133**	Plan first recipient must be seen by a plan first network provider
42	Charges exceed our fee schedule or maximum allowable amount.	**N14**	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.	**89**	Medicare paid amount equal to 100%.
42	Charges exceed our fee schedule or maximum allowable amount.	**N14**	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.	**354**	Encounter rate paid, if any, represents the maximum amount allowed by Medicaid.
42	Charges exceed our fee schedule or maximum allowable amount.	**N14**	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.	**357**	Payment amount, if any, represents the maximum payment allowed by Medicaid.
42	Charges exceed our fee schedule or maximum allowable amount.			**360**	Payment amount if any represents the maximum payment allowed by Medicaid.
42	Charges exceed our fee schedule or maximum allowable amount.	**N14**	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.	**363**	Payment, if any, represents the allowance made by Medicaid after considering Medicare liability.
42	Charges exceed our fee schedule or maximum allowable amount.			**365**	Fee adjusted to maximum allowable.
42	Charges exceed our fee schedule or maximum allowable amount.	**N14**	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.	**367**	Paid in full by Medicaid.
42	Charges exceed our fee schedule for maximum allowable amount.	**N14**	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.	**730**	ESWL pricing.
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid. This code will be deactivated on 2/1/2006. Replaced with ARC 167.			**39**	Services are not covered for indicated diagnosis.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid. This code will be deactivated on 2/1/2006. Replaced with ARC 167.	**M76**	Missing/incomplete/ invalid diagnosis or condition.	**76**	The diagnosis code billed is not covered for MHSP.
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid. This code will be deactivated on 2/1/2006. Replaced with ARC 167.			**190**	Primary diagnosis code is invalid or non-covered.
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid. This code will be deactivated on 2/1/2006. Replaced with ARC 167.	**M64**	Missing/Incomplete/ invalid other diagnosis.	**191**	Secondary diagnosis code is invalid or non-covered.
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid. This code will be deactivated on 2/1/2006. Replaced with ARC D21.	**M64**	Missing/Incomplete/invalid other diagnosis.	**192**	The third diagnosis code is invalid.
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid. This code will be deactivated on 2/1/2006. Replaced with ARC D21.	**M64**	Missing/Incomplete/ invalid other diagnosis.	**193**	Fourth diagnosis code is invalid.
47	This (these) diagnosis (es) is (are) not covered, missing, or are invalid. This code will be deactivated on 2/1/2006. Replaced with ARC D21.			**198**	Primary diagnosis code must be billed at highest subdivision.
47	This (these) diagnosis (es) is (are) not covered, missing, or are invalid. This code will be deactivated on 2/1/2006. Replaced with ARC D21.	**M64**	Missing/incomplete/ invalid other diagnosis.	**199**	Other diagnosis code must be billed at highest subdivision.
47	This (these) diagnosis (es) is (are) not covered, missing, or are invalid. This code will be deactivated on 2/1/2006. Replaced with ARC 167.			**200**	Primary diagnosis code not covered.
47	This (these) diagnosis (es) is (are) not covered, missing, or are invalid. This code will be deactivated on 2/1/2006. Replaced with ARC 167.	**M64**	Missing/incomplete/invalid other diagnosis.	**201**	Other diagnosis code not covered.
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid. This code will be deactivated on 2/1/2006. Replaced with ARC 167.			**205**	Detail diagnosis is not on file.
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid. This code will be deactivated on 2/1/2006. Replaced with ARC D21.	**MA65**	Missing/incomplete/ invalid admitting diagnosis.	**313**	Admitting diagnosis is missing, invalid or not on file.
52	The referring/prescribing/ rendering provider is not eligible to refer/prescribe/ order/perform the service billed. This code will be deactivated on 2/1/2006. Replaced with ARC 183.			**48**	Referring provider must be a valid EPSDT screening provider. Contact EDS for a screening provider listing.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
52	The referring/prescribing/ rendering provider is not eligible to refer/prescribe/ order/perform the service billed. This code will be deactivated on 2/1/2006. Replaced with ARC 185.			**50**	EPSDT screenings may only be billed by an EPSDT screening provider. Contact the provider enrollment unit at EDS.
52	The referring/prescribing/ rendering provider is not eligible to refer/prescribe/ order/perform the service billed. This code will be deactivated on 2/1/2006. Replaced with ARC 185.			**65**	Procedure billed is invalid for provider.
52	The referring/prescribing/ rendering provider is not eligible to refer/prescribe/ order/perform the service billed. This code will be deactivated on 2/1/2006. Replaced with ARC 185.			**74**	Type 30 for county health department is limited to providing services for recipients under 21. (EPSDT only provider billed non-EPSDT referral claim).
52	The referring/prescribing/ rendering provider is not eligible to refer/prescribe/ order/perform the service billed. This code will be deactivated on 2/1/2006. Replaced with ARC 185.	**N95**	This provider type/provider specialty may not bill this service.	**77**	PC invalid for this provider number.
52	The referring/ Prescribing/ rendering provider is not eligible to refer/prescribe/ order/perform the service billed. This code will be deactivated on 2/1/2006. Replaced with ARC 185.			**85**	Maternity care provider restricted to maternity service.
52	The referring/prescribing/ rendering provider is not eligible to refer/prescribe/ order/perform the service billed. This code will be deactivated on 2/1/2006. Replaced with ARC 185.			**221**	Enrollment file indicates provider is deceased.
52	The referring/prescribing/ rendering provider is not eligible to refer/prescribe/order/ perform the service billed. This code will be deactivated on 2/1/2006. Replaced with ARC 185.			**223**	Provider is suspended from the Medicaid program.
52	The referring/prescribing/ rendering provider is not eligible to refer/prescribe/order/ perform the service billed. This code will be deactivated on 2/1/2006. Replaced with ARC 185.			**227**	Provider is enrolled in the Medicaid program for crossovers claims only.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
52	The referring/prescribing/ rendering provider is not eligible to refer/prescribe/order/ perform the service billed. This code will be deactivated on 2/1/2006. Replaced with ARC 185.			**239**	Provider eligible for only QMB recipients and EPSDT referrals.
52	The referring/prescribing/ rendering provider is not eligible to refer/prescribe/order/ perform the service billed. This code will be deactivated on 2/1/2006. Replaced with ARC 185.			**258**	Medicaid has restricted the services of this recipient to a specific provider and/or specific drugs.
52	The referring/prescribing/ rendering provider is not eligible to refer/ prescribe/ order/perform the service billed. This code will be deactivated on 2/1/2006. Replaced with ARC 185.			**300**	Provider not enrolled for VFC program.
52	The referring/prescribing/ rendering provider is not eligible to refer/prescribe/ order/perform the service billed. This code will be deactivated on 2/1/2006. Replaced with ARC 184.	**N31**	Missing/incomplete/ invalid prescribing provider identifier.	**907**	The prescribing provider's license number is missing or invalid.
57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply. This code will be deactivated. Replaced with ARC 154.			**903**	The days supply is greater than the authorized days, or is invalid.
57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply. This code will be deactivated. Replaced with ARC 151.			**911**	Refill number is missing, greater than five or is greater than the refill authorization.
58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.			**144**	Place of service code is not valid for provider type.
58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.			**956**	This claim has been adjusted to reflect a change in the type of service.
59	Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.	**N59**	Please refer to your provider manual for additional program and provider information.	**769**	Secondary surgical procedure within the same incision paid at 50% of Medicaid allowed.

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59	Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.	**N59**	Please refer to your provider manual for additional program and provider information.	**884**	Regional anesthesia payment is 50% of level III price.
62	Payment denied/reduced for absence of, or exceeded, precertification/authorization .	**N286**	Missing/incomplete/ invalid referring provider identifier.	**106**	Anesthesia claims require referring provider.
62	Payment denied/reduced for absence of, or exceeded, precertification/authorization .			**158**	Recipient eligible for emergency services only.
62	Payment denied/reduced for absence of, or exceeded, precertification/authorization .	**M62**	Missing/incomplete/ invalid treatment authorization code.	**375**	Drug code requires a PA for product selection.
62	Payment denied/reduced for absence of, or exceeded, pre-certification/ authorization.			**391**	The dos spans a pa change. Call EDS provider assistance center at 1(800) 688-7989 for assistance.
62	Payment denied/reduced for absence of, or exceeded, pre-certification/ authorization.			**392**	Units of service exceed the authorized units on the pa file.
62	Payment denied/reduced for absence of, or exceeded, pre-certification/ authorization			**398**	Claim allowed charge is more than the authorized amount on the pa file.
62	Payment denied/reduced for absence of, or exceeded, pre-certification/ authorization.	**M123**	Missing/incompleted/ invalid name, strength, or dosage of the drug.	**420**	Qty dispensed exceeds max quantity based on PA.
88	Adjustment amount represents collection against receivable created in prior overpayment. This code will be deactivated. Replaced with ARC 125.			**116**	Recoupment - this amount is withheld from your check.
88	Adjustment amount represents collection against receivable created in prior overpayment. This code will be deactivated. Replaced with ARC 125.			**119**	Payment amount applied to receivable.
96	Non-covered charge(s).			**17**	A SLMB recipient (aid categories 92, 93, 94) is not eligible for Medicaid services.
96	Non-covered charge(s).			**40**	Procedure code limited to QMB or EPSDT related claims.
96	Non-covered charge(s).	**N39**	Procedure code is not compatible with tooth number/letter.	**69**	Dental sealants are not payable for this recipient or tooth number.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
96	Non-covered charge(s).	**N30**	Recipient ineligible for this service.	**73**	Family planning service not covered for this recipient.
96	Non-covered charge(s).	**M46**	Missing/incomplete/ invalid occurrence span code(s).	**78**	Critical care procedure cannot span more than two days.
96	Non-covered charge(s).	**N30**	Recipient ineligible for this service.	**84**	Service billed is not covered for a SOBRA eligible recipient
96	Non-covered charge(s).			**86**	Recipient not eligible for targeted case management.
96	Non-covered charge(s).			**98**	Service not covered by Medicaid.
96	Non-covered charge(s).	**M50**	Missing/incomplete/ invalid revenue code(s).	**111**	Inpatient/outpati ent non-covered revenue codes for EPSDT referred claims.
96	Non-covered charge(s).	**N39**	Procedure code is not compatible with tooth number/letter.	**129**	Procedure not covered for tooth number.
96	Non-covered charge(s).	**N30**	Recipient ineligible for this service.	**134**	Plan first recipient is only eligible for plan first services.
96	Non-covered charge(s).			**160**	Part-b charges billed by NH provider are not covered by Medicaid (lt).
96	Non-covered charge(s).			**163**	This procedure code is not covered for non-Medicare related claims.
96	Non-covered charge(s).			**356**	This drug is not available as an injectable.
96	Non-covered charge(s).			**368**	This service is not covered by Medicaid.
96	Non-covered charge(s).			**370**	The assistant surgeon's fee for this procedure is not covered.
96	Non-covered charge(s).			**424**	Medicaid has no liability for this claim since Medicare/ Medicaid days run concurrently.
96	Non-covered charge(s).	**N20**	Service not payable with other service rendered on the same date.	**764**	This procedure code is not covered when billed with medical psychotherapy codes.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
97	Payment is included in the allowance for another service/procedure.			**75**	Procedure code A0330 is an inclusive code. Only mileage and return trip may be billed in addition.
97	Payment is included in the allowance for another service/procedure.			**105**	This service is included in the facility fee (revenue code 450).
97	Payment is included in the allowance for another service/procedure.	**N20**	Service not payable with other service rendered on the same date.	**421**	Subsequent procedure included in primary anesthesia charge.
97	Payment is included in the allowance for another service/procedure.			**576**	This procedure is part of another procedure performed on the same day.
97	Payment is included in the allowance for another service/procedure			**580**	Administration fee may not be billed on the same day as an office visit and/or vaccine replacement
97	Payment is included in the Allowance for another Service/procedure.			**729**	Venipuncture and lab codes are not allowed on the same day.
97	Payment is included in the Allowance for another Service/procedure.	**N19**	Procedure code incidental to primary procedure.	**731**	Procedure is inclusive in primary procedure.
97	Payment is included in the Allowance for another Service/procedure.	**N20**	Service not payable with other service rendered on the same date.	**732**	Payment made for similar procedure.
97	Payment is included in the allowance for another service/procedure.			**733**	This service is included in the facility fee
97	Payment is included in the allowance for another service/procedure.			**734**	Procedure not covered with specific codes.
97	Payment is included in the allowance for another service/procedure.	**M86**	Service denied because payment already made for similar procedure within set time frame.	**735**	Same provider cannot bill application/ removal/repair of cast for the same recipient.
97	Payment is included in the allowance for another service/procedure.	**N20**	Service not payable with other service rendered on the same date.	**754**	This procedure is part of another procedure performed on the same day.
97	Payment is included in the allowance for another service/procedure.	**N20**	Service not payable with other service rendered on the same date.	**849**	This procedure cannot be billed in addition to the delivery code billed.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
97	Payment is included in the allowance for another service/procedure.	**N20**	Service not payable with other service rendered on the same date.	**850**	Biopsy of ovary may not be billed with another exam on the same day.
97	Payment is included in the allowance for another service/procedure.	**N20**	Service not payable with other service rendered on the same date.	**851**	Exploratory lap/lysis of adhesions may not be billed on the same day with other related surgery.
97	Payment is included in the allowance for another service/procedure.			**852**	This x-ray procedure may not be billed within 30 (thirty) days of a root canal
97	Payment is included in the allowance for another service/procedure.	**N20**	Service not payable with other service rendered on the same date.	**854**	Emergency oral exam may not be billed with definitive treatment the same day.
97	Payment is included in the allowance for another service/procedure.	**N20**	Service not payable with other service rendered on the same date.	**861**	Antepartum, postpartum care/vaginal delivery may not be billed with global ob care.
97	Payment is included in the allowance for another service/procedure.	**N20**	Service not payable with other service rendered on the same date.	**864**	Hysterectomy ancillary codes may not be paid in addition to the hysterectomy procedure code.
97	Payment is included in the allowance for another service/procedure.	**N20**	Service not payable with other service rendered on the same date.	**865**	Hospital admission/visits may not be billed on or after ob global.
97	Payment is included in the allowance for another service/procedure.	**N20**	Service not payable with other service rendered on the same date.	**868**	Local anesthesia procedures are covered in the total ob cost and may not be billed separately with a delivery procedure code.
97	Payment is included in the allowance for another service/procedure.			**873**	Routine ancillary services associated with an abortion are covered in the total abortion cost and are not reimbursable separately.
97	Payment is included in the allowance for another service/procedure.	**N20**	Service not payable with other service rendered on the same date.	**879**	Administration fee may not be billed on the same day as an office visit and or vaccine replacement.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
97	Payment is included in the allowance for another service/procedure.			**886**	Visual fields/tonometry is covered in the complete eye exam.
97	Payment is included in the allowance for another service/procedure.			**888**	Post-operative physician services for the same diagnosis may not be billed within 62 days of surgery.
97	Payment is included in the allowance for another service/procedure.	**N20**	Service not payable with other service rendered on the same date.	**890**	Procedure code is not covered when outpatient surgical procedure is billed.
97	Payment is included in the allowance for another service/procedure.	**N20**	Service not payable with other service rendered on the same date.	**895**	Routine prenatal lab, office/hospital visits may not be billed with global ob procedure.
97	Payment is included in the allowance for another service/procedure.			**896**	Postpartum services may not be billed with global ob on or within 62 days of delivery.
97	Payment is included in the allowance for another service/procedure.	**N20**	Service not payable with other service rendered on the same date.	**898**	This procedure is part of another procedure performed on the same day.
105	Tax withholding.	**MA45**	As previously advised, a portion or all of your payment is being held in a special account.	**117**	Refund check amount credited to your IRS year total.
105	Tax withholding.	**MA45**	As previously advised, a portion or all of your payment is being held in a special account.	**118**	Returned check amount credited to your IRS year total.
107	Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim.	**N59**	Please refer to your provider manual for additional program and provider information.	**611**	No extraction code in history in 180 day time frame.
109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.			**59**	Maternity waiver/care claim must be billed by contract provider
109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	**MA64**	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.	**428**	Third party liability suspect.
110	Billing date predates service date.	**M52**	Missing/incomplete/ invalid "from" date(s) of service.	**100**	Detail from date of service is a future date or invalid.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
119	Benefit maximum for this time period or occurrence has been reached .			**162**	Units billed exceed maximum allowed per day.
119	Benefit maximum for this time period or occurrence has been reached.			**400**	Procedure is limited to six (6) per calendar month.
119	Benefit maximum for this time period or occurrence has been reached.			**401**	Procedure is limited to fifteen (15) per calendar month.
119	Benefit maximum for this time period or occurrence has been reached.			**402**	Procedure is limited to one (1) every two years.
119	Benefit maximum for this time period or occurrence has been reached.			**403**	Procedure is limited to thirty (30) per month.
119	Benefit maximum for this time period or occurrence has been reached.			**405**	Procedure code is limited to one-hundred (100) per month.
119	Benefit maximum for this time period or occurrence has been reached.			**407**	Procedure is limited to 60 (sixty) times per calendar month
119	Benefit maximum for this time period or occurrence has been reached.			**408**	Procedure is limited to 30 (thirty) per month.
119	Benefit maximum for this time period or occurrence has been reached.			**409**	Procedure code is limited to 40 (forty) per calendar month
119	Benefit maximum for this time period or occurrence has been reached.			**410**	This procedure is limited to eighteen (18) units per calendar year.
119	Benefit maximum for this time period or occurrence has been reached.			**411**	Procedure is limited to 1 (one) every two years.
119	Benefit maximum for this time period or occurrence has been reached.	**N43**	Bed hold or leave days exceeded.	**422**	Revenue code 184 is limited to 14 days per calendar month.
119	Benefit maximum for this time period or occurrence has been reached.	**N59**	Please refer to your provider manual for additional program and provider information.	**448**	Qualifying procedure limit has been exceeded.
119	Benefit maximum for this time period or occurrence has been reached.			**412**	Family planning periodic follow-up is limited to four (4) visits per year.
119	Benefit maximum for this time period or occurrence has been reached.			**413**	Procedure code is limited to 100 per month.
119	Benefit maximum for this time period or occurrence has been reached.			**414**	Ob ultrasound limit has been reached for this recipient. .Any further will require prior authorization.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
119	Benefit maximum for this time period or occurrence has been reached.			**415**	Screening mammography is limited to one per year.
119	Benefit maximum for this time period or occurrence has been reached.			**416**	The limit of two units per month has been exceeded for this procedure.
119	Benefit maximum for this time period or occurrence has been reached.			**423**	The quantity dispensed exceeds the maximum quantity allowed for the drug code prescribed.
119	Benefit maximum for this time period or occurrence has been reached.			**436**	HBO limit has been exceeded.
119	Benefit maximum for this time period or occurrence has been reached.			**437**	Vision and hearing screening one per year.
119	Benefit maximum for this time period or occurrence has been reached.			**441**	Number of home health visits exceed limit.
119	Benefit maximum for this time period or occurrence has been reached.			**442**	The yearly limit for this procedure has been exceeded.
119	Benefit maximum for this time period or occurrence has been reached.			**443**	The yearly limit for this procedure has been exceeded.
119	Benefit maximum for this time period or occurrence has been reached.			**444**	The yearly limit for this procedure has been exceeded.
119	Benefit maximum for this time period or occurrence has been reached.			**445**	The yearly limit for this procedure has been exceeded.
119	Benefit maximum for this time period or occurrence has been reached.			**452**	The quantity dispensed is not numeric or exceeds the maximum quantity allowed for the drug prescribed.
119	Benefit maximum for this time period or occurrence has been reached.			**483**	The limit of three units per month has been exceeded for this procedure.
119	Benefit maximum for this time period or occurrence has been reached.			**484**	The limit of three (3) units per month has been exceeded for this procedure.
119	Benefit maximum for this time period or occurrence has been reached.			**485**	The limit of two units per month has been exceeded for this procedure.
119	Benefit maximum for this time period or occurrence has been reached.			**489**	The limit for these services has been

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
					reached for this contract year.
119	Benefit maximum for this time period or occurrence has been reached.			**492**	Monthly script limit exceeded.
119	Benefit maximum for this time period or occurrence has been reached.			**539**	This procedure code is limited to one per calendar month.
119	Benefit maximum for this time period or occurrence has been reached.			**559**	Inpatient/ outpatient/asc visits have been exceeded for the calendar year
119	Benefit maximum for this time period or occurrence has been reached.			**560**	Outpatient visits have been exceeded for this calendar year.
119	Benefit maximum for this time period or occurrence has been reached.			**564**	This ambulance service procedure code is limited to four units per calendar month.
119	Benefit maximum for this time period or occurrence has been reached.			**574**	More than one contact lens fitting cannot be billed for the same date of service.
119	Benefit maximum for this time period or occurrence has been reached.			**577**	Units billed for procedure code exceed maximum units allowed.
119	Benefit maximum for this time period or occurrence has been reached.			**579**	Independent rural health clinics cannot be paid for more than one service per day.
119	Benefit maximum for this time period or occurrence has been reached.			**587**	Procedure limited to 720 hours per calendar year.
119	Benefit maximum for this time period or occurrence has been reached.			**592**	Vision and hearing screening must be billed with a regular screening and are limited to once per year.
119	Benefit maximum for this time period or occurrence has been reached.			**593**	The yearly limit for this procedure has been exceeded.
119	Benefit maximum for this time period or occurrence has been reached.	**N59**	Please refer to your provider manual for additional program and provider information.	**617**	Emergency oral exam (d0140) limited to once per calendar year.
119	Benefit maximum for this time period or occurrence has been reached.	**N117**	This service is paid only once in a lifetime per beneficiary.	**618**	D1351 is limited to once per tooth per recipient's lifetime.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
119	Benefit maximum for this time period or occurrence has been reached.	**N59**	Please refer to your provider manual for additional program and provider information.	**619**	Procedure code limited to once every 6 months.
119	Benefit maximum for this time period or occurrence has been reached.	**N59**	Please refer to your provider manual for additional program and provider information.	**620**	Prophylaxis is limited to once every 6 months.
119	Benefit maximum for this time period or occurrence has been reached.			**622**	This procedure is limited to one per postpartum period.
119	Benefit maximum for this time period or occurrence has been reached.	**N59**	Please refer to your provider manual for additional program and provider information.	**623**	Fluoride is limited to once every 6 months.
119	Benefit maximum for this time period or occurrence has been reached.			**630**	Units billed for procedure code exceed maximum units allowed.
119	Benefit maximum for this time period or occurrence has been reached.			**631**	The yearly limit for this procedure has been exceeded.
119	Benefit maximum for this time period or occurrence has been reached.			**634**	Procedure limited to 1080 hours per waiver year October 1-September 30.
119	Benefit maximum for this time period or occurrence has been reached.			**640**	Mental health diagnostic testing limit.
119	Benefit maximum for this time period or occurrence has been reached.			**641**	This procedure is limited to one episode a year.
119	Benefit maximum for this time period or occurrence has been reached.			**642**	This procedure is limited to 52 units per year.
119	Benefit maximum for this time period or occurrence has been reached.			**644**	Procedure code is limited to 104 units a year.
119	Benefit maximum for this time period or occurrence has been reached.			**645**	Procedure code is limited to 104 times per year.
119	Benefit maximum for this time period or occurrence has been reached.			**646**	Procedure code is limited to 104 times a year.
119	Benefit maximum for this time period or occurrence has been reached.			**647**	This procedure is limited to 365 episodes a year.
119	Benefit maximum for this time period or occurrence has been reached.			**648**	This procedure is limited to 52 units a year.
119	Benefit maximum for this time period or occurrence has been reached.			**649**	Benefits have been exceeded for the calendar year.
119	Benefit maximum for this time period or occurrence has been reached.			**650**	Benefits have been exceeded for the calendar year.

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119	Benefit maximum for this time period or occurrence has been reached.			**651**	Benefits have been exceeded for the calendar year.
119	Benefit maximum for this time period or occurrence has been reached.			**652**	Benefits have been exceeded for the calendar year.
119	Benefit maximum for this time period or occurrence has been reached.			**654**	Benefits have been exceeded for the calendar year.
119	Benefit maximum for this time period or occurrence has been reached.			**656**	Procedure is limited to 260 units a year.
119	Benefit maximum for this time period or occurrence has been reached.			**657**	Procedure is limited to 260 units a year.
119	Benefit maximum for this time period or occurrence has been reached.			**658**	Procedure is limited to 8 units a year.
119	Benefit maximum for this time period or occurrence has been reached.			**659**	Procedure code is limited to 312 units a year.
119	Benefit maximum for this time period or occurrence has been reached.			**660**	Procedure is limited to 1040 units a year.
119	Benefit maximum for this time period or occurrence has been reached.			**661**	Procedure is limited to 1040 units a year.
119	Benefit maximum for this time period or occurrence has been reached.			**662**	Procedure is limited to 2016 units a year.
119	Benefit maximum for this time period or occurrence has been reached.			**670**	Procedure is limited to 130 units a calendar year.
119	Benefit maximum for this time period or occurrence has been reached.			**671**	Procedure code is limited to 20 (twenty) per calendar month
119	Benefit maximum for this time period or occurrence has been reached.			**672**	Procedure is limited to 104 times a calendar year.
119	Benefit maximum for this time period or occurrence has been reached.			**673**	Procedure is limited to 365 times a calendar year.
119	Benefit maximum for this time period or occurrence has been reached.			**683**	Yearly limit for crisis intervention has been exceeded
119	Benefit maximum for this time period or occurrence has been reached.			**684**	The yearly limit for this procedure has been exceeded
119	Benefit maximum for this time period or occurrence has been reached.	**N59**	Please refer to your provider manual for additional program and provider information.	**692**	This procedure is limited to 12 units every 24 months.
119	Benefit maximum for this time period or occurrence has been reached.			**697**	The limit for these services has been reached for the calendar year.

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119	Benefit maximum for this time period or occurrence has been reached.			**698**	The limit for these services has been reached for the calendar year.
119	Benefit maximum for this time period or occurrence has been reached.			**699**	Procedure is limited to once every thirty (30) days by the same billing provider.
119	Benefit maximum for this time period or occurrence has been reached.			**701**	Procedure limited to two per lifetime per tooth.
119	Benefit maximum for this time period or occurrence has been reached.			**702**	Dental re-cement of crowns not allowed within 180 days of crowns.
119	Benefit maximum for this time period or occurrence has been reached.			**707**	Initial screening is limited to once per lifetime.
119	Benefit maximum for this time period or occurrence has been reached.			**708**	Psychotherapy services are limited to 12 (twelve) per calendar year at place of service "21" (inpatient).
119	Benefit maximum for this time period or occurrence has been reached.			**710**	Diagnostic assessments are limited to one encounter per calendar year.
119	Benefit maximum for this time period or occurrence has been reached.	**N59**	Please refer to your provider manual for additional program and provider information.	**712**	Procedure is limited to 4160 units a year.
119	Benefit maximum for this time period or occurrence has been reached.			**718**	New patient code Z5147 may only be billed once per lifetime per recipient.
119	Benefit maximum for this time period or occurrence has been reached.			**719**	The procedure code billed is limited to one unit per day.
119	Benefit maximum for this time period or occurrence has been reached.			**723**	Procedure code is limited to 156 units per calendar year.
119	Benefit maximum for this time period or occurrence has been reached.			**727**	Procedure code is limited to one unit per calendar month.
119	Benefit maximum for this time period or occurrence has been reached.			**728**	Procedure code is limited to 12 units per lifetime.
119	Benefit maximum for this time period or occurrence has been reached.			**741**	MHSP clinic visit limit has been exceeded.
119	Benefit maximum for this time period or occurrence has been reached.			**744**	EPSDT screening limit has been exceeded.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
119	Benefit maximum for this time period or occurrence has been reached.			**745**	EPSDT screening limit has been exceeded.
119	Benefit maximum for this time period or occurrence has been reached.			**749**	This procedure is limited to six units per calendar year.
119	Benefit maximum for this time period or occurrence has been reached.			**750**	This procedure is limited to three units per calendar year.
119	Benefit maximum for this time period or occurrence has been reached.			**753**	More than one obstetrical delivery code may not be billed within six months.
119	Benefit maximum for this time period or occurrence has been reached.			**760**	Initial visit is limited to one per recipient, per provider, per lifetime.
119	Benefit maximum for this time period or occurrence has been reached.			**761**	This procedure code is limited to one every calendar year.
119	Benefit maximum for this time period or occurrence has been reached.			**768**	Procedure is limited to 30 (thirty) per month.
119	Benefit maximum for this time period or occurrence has been reached.	**N59**	Please refer to your provider manual for additional program and provider information.	**770**	Procedure code is limited to one occurrence every six months.
119	Benefit maximum for this time period or occurrence has been reached.			**771**	Maximum unit limit has been exceeded.
119	Benefit maximum for this time period or occurrence has been reached.	**N59**	Please refer to your provider manual for additional program and provider information.	**772**	Oral exam evaluations are limited to one per day.
119	Benefit maximum for this time period or occurrence has been reached.			**780**	Procedure code is limited to one per recipient within sixty days of delivery.
119	Benefit maximum for this time period or occurrence has been reached.			**788**	Procedure code 11795 is limited to one every 365 days and procedure code 11977 cannot be billed within 60 months of insertion.
119	Benefit maximum for this time period or occurrence has been reached.			**789**	Only one initial NICU procedure may be billed per hospital stay.
119	Benefit maximum for this time period or occurrence has been reached.			**790**	Procedure is limited to two per year.
119	Benefit maximum for this time period or occurrence has been reached.			**793**	Binaural hearing aid repair is limited to two.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
					every six months
119	Benefit maximum for this time period or occurrence has been reached.	**N59**	Please refer to your provider manual for additional program and provider information.	**797**	Medical supplies limit is 1800.00 per waiver year, 02/22-02/21. The limit has been exceeded.
119	Benefit maximum for this time period or occurrence has been reached.			**799**	Requested inpatient hospital services partially exceed limit of 16. Rebill for remaining days.
119	Benefit maximum for this time period or occurrence has been reached.			**800**	Procedure code is limited to one occurrence every six months
119	Benefit maximum for this time period or occurrence has been reached.			**802**	Newborn code may not be billed more than once.
119	Benefit maximum for this time period or occurrence has been reached.			**806**	Batteries may not be purchased within 60 (sixty) days of purchase of hearing aid.
119	Benefit maximum for this time period or occurrence has been reached.			**807**	Procedure limited to one service during 60 (sixty) day postpartum period.
119	Benefit maximum for this time period or occurrence has been reached.			**813**	Procedure is limited to one every 4 calendar years.
119	Benefit maximum for this time period or occurrence has been reached.			**816**	The limit of three units per month has been exceeded for this procedure
119	Benefit maximum for this time period or occurrence has been reached.			**817**	The limit of two units per month has been exceeded for this procedure.
119	Benefit maximum for this time period or occurrence has been reached.			**821**	EPSDT screening limit has been exceeded.
119	Benefit maximum for this time period or occurrence has been reached.			**822**	This procedure code is limited to one per month.
119	Benefit maximum for this time period or occurrence has been reached.	**N59**	Please refer to your provider manual for additional program and provider information.	**823**	Full series/panoramic x-rays are limited to one every three calendar years.
119	Benefit maximum for this time period or occurrence has been reached.			**825**	Procedure is limited to one service every 70 days.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
119	Benefit maximum for this time period or occurrence has been reached.			**829**	Binaural are limited to two every four months.
119	Benefit maximum for this time period or occurrence has been reached.			**830**	Specimen collection fee is limited to one per day.
119	Benefit maximum for this time period or occurrence has been reached.			**832**	Binaural hearing aid batteries are limited to two packages every two months.
119	Benefit maximum for this time period or occurrence has been reached.			**837**	Procedure code is limited to one in a series.
119	Benefit maximum for this time period or occurrence has been reached.			**838**	Specimen collection fee is limited to one per day.
119	Benefit maximum for this time period or occurrence has been reached.			**842**	Comprehensive dental exam may only be billed once per lifetime per provider.
119	Benefit maximum for this time period or occurrence has been reached.			**856**	The yearly limit for this procedure has been exceeded.
119	Benefit maximum for this time period or occurrence has been reached.			**859**	The same provider may not bill more than one new patient office visit per recipient.
119	Benefit maximum for this time period or occurrence has been reached.			**862**	Leg bags are limited to two per month.
119	Benefit maximum for this time period or occurrence has been reached.			**863**	The yearly limit for this procedure has been exceeded.
119	Benefit maximum for this time period or occurrence has been reached.			**874**	Procedure is limited to one (1) every two years.
119	Benefit maximum for this time period or occurrence has been reached.			**875**	Inpatient/outpatient visits have been exceeded for this calendar year.
119	Benefit maximum for this time period or occurrence has been reached.			**877**	Procedure is limited to one (1) every three years.
119	Benefit maximum for this time period or occurrence has been reached.			**881**	Procedure code is limited to one in a series.
119	Benefit maximum for this time period or occurrence has been reached.			**887**	Catheters, catheter trays, and drainage bags are limited to two per month.
119	Benefit maximum for this time period or occurrence has been reached.			**889**	Requested inpatient hospital services exceed limit of 16.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
119	Benefit maximum for this time period or occurrence has been reached.			**891**	Physician office visit limitation has been exceeded.
119	Benefit maximum for this time period or occurrence has been reached.			**892**	Initial critical care limited to one per day.
119	Benefit maximum for this time period or occurrence has been reached.			**983**	Claim adjusted/recouped because physician office visits have been exceeded for calendar year.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**955**	The claim has been adjusted to reflect changes in the number of units billed and paid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M52**	Missing/Incomplete/ invalid "from" date(s) of service.	**1**	The "from" date of service is invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**MA40**	Missing/Incomplete/ invalid admission date.	**2**	The admission date is invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M59**	Missing/Incomplete/ invalid "to" date(s) of service.	**3**	The through date of service is invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M54**	Missing/incomplete/ invalid total charges.	**4**	The total non-covered charge is invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**MA31**	Missing/ Incomplete/invalid beginning and ending dates of the period billed.	**5**	The surgical date is not between admit and through dates of service.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**6**	Submitted charge for the line item is equal to or less than non-covered charge.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks	**MA32**	Missing/Incomplete/ invalid number of covered days during the billing period.	**7**	Number of days billed and billing period disagree.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
	codes whenever appropriate.				
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N50**	Missing/incomplete/ invalid discharge information.	**9**	The discharge date is earlier than the admission date. Transportation: describe other charges.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N74**	Resubmit with multiple claims, each claim covering services provided in only one calendar month	**16**	Ip-dos must not span 2 calendar years, span a rate change, or exceed 99 days.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**MA32**	Missing/Incomplete/ Invalid number of covered days during the billing period.	**22**	Covered days billed are invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**28**	Header paid amount cannot be greater than specified dollar amount.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M53**	Missing/incomplete/ Invalid days or units of service.	**31**	Units (total days) x rate does not equal the total accommodation charge.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M54**	Missing/incomplete/ Invalid total charges.	**36**	Submitted rate, units, and total charge do not balance.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N65**	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/ provider.	**38**	Pricing file indicates zero price. Call EDS.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M54**	Missing/incomplete/ Invalid total charges.	**43**	Billed amount must be numeric and greater than zero.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**44**	Medicare paid amount is missing or invalid.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**45**	The Medicare allowed amount is missing or invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**46**	Medicare total billed amount is missing or invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**MA43**	Missing/incomplete Invalid patient status.	**51**	Patient status invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M79**	Missing/incomplete/ Invalid charge.	**52**	Medicare header allowed amount does not equal the sum of detail Medicare allowed amounts.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M54**	Missing/incomplete/ Invalid total charges.	**53**	Net billed amount not equal to sum of detail charges less TPL amount.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M54**	Missing/ Incomplete/ Invalid total charges.	**54**	The sum of the detail noncovered charge does not equal the header noncovered charge.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M54**	Missing/ Incomplete/ Invalid total charges.	**55**	Billed amount not equal to sum of the detail charge amounts.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M54**	Missing/ Incomplete/ Invalid total charges.	**56**	The Medicare header paid amount does not equal the sum of the detail Medicare paid amounts.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**MA37**	Missing/ Incomplete/ Invalid patient's address.	**63**	Recipient's county of residence for claim dates of service are not on file. Resubmit.
125	Payment adjusted due to a submission/billing error(s). Additional information is	**MA41**	Missing/incomplete/ Invalid admission type.	**66**	Admit type is invalid as billed.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
	supplied using the remittance advice remarks codes whenever appropriate.				
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N61**	Rebill services on separate claims.	**87**	Different targeted case management procedure codes must be billed on separate claims.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**MA35**	Missing/incomplete/invalid number of lifetime reserve days.	**95**	Lifetime reserve days are invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**99**	Medicare deductible amount is invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M59**	Missing/Incomplete/ invalid "to" date(s) of service.	**101**	The to date is invalid or prior to the from date.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**110**	Invalid deductible amount for skilled nursing facility.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**116**	Recoupment-this amount is withheld from your check.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**119**	Payment amount applied to receivable.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N346**	Missing/incomplete/ invalid oral cavity designation code.	**123**	Oral cavity designation code invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N57**	Missing/incomplete/ invalid prescribing date.	**125**	Dispensed date invalid (ph).

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N37**	Missing/incomplete/ Invalid tooth number/letter.	**126**	The tooth surface on the dental request is missing/invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N37**	Missing/incomplete/ invalid tooth number/letter.	**128**	A valid tooth number is required for procedure.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N30**	Recipient ineligible for this service.	**135**	Procedure restricted to technology assisted waiver recipients.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M50**	Missing/ Incomplete/ invalid revenue code(s).	**151**	Revenue/ procedure code/NCD is invalid for dos.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**152**	Procedure, revenue code or drug code is invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M50**	Missing/ incomplete/invalid revenue code(s).	**161**	Procedure code or revenue code is invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M67**	Missing/ Incomplete/ invalid other procedure code(s).	**175**	Operation or delivery requires surgical procedure code.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N51**	Electronic interchange agreement not on file for provider/submitter.	**220**	Provider has not been approved to bill electronic media claims.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N65**	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	**225**	Date of service is not within the provider rate segments.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks	**N34**	Incorrect claim form for this service.	**226**	Claim type is not valid for this provider.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
	codes whenever appropriate.				
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**229**	Provider number is invalid, not on file or name/number disagree.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**230**	The attending physician's license number is missing or invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**233**	The referring provider is not on file or is not a valid referring provider.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N55**	Procedures for billing with group/referring/performing providers were not followed.	**235**	The billing provider must be the group provider number.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N55**	Procedures for billing with group/ referring/ performing providers were not followed.	**236**	Performing provider cannot be group provider number.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**MA112**	Missing/incomplete/ invalid group practice information.	**238**	Performing provider is not associated with the group.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**295**	Production provider cannot bill claims for test recipient/test provider cannot bill claims for production recipient
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N31**	Missing incomplete/ invalid prescribing provider identifier.	**304**	The operating physicians license number is missing or not on file.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N74**	Resubmit with multiple claims, each claim covering services provided in only one calendar month	**308**	The detail dos spanned the provider fiscal year beginning/end dates.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**310**	The claim line item and/or total charge is missing, not numeric or calculated incorrectly.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**311**	The non-covered charge amount is invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N74**	Resubmit with multiple claims, each claim covering services provided in only one calendar month	**314**	Outpatient span billing is limited to no more than one calendar month per claim.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N61**	Rebill services on separate claims	**315**	Dos cannot span 1999 and 2000. Split bill claim.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N54**	Claim information is inconsistent with pre-certified/authorized services.	**319**	Covered days are greater than certified days. Refile only for certified days up to Medicaid's limitation.
125	Payment adjusted due to a submission/billing error(s).	**N54**	Claim information is inconsistent with pre-certified/authorized services.	**320**	PSRO/UR data is missing or invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M52**	Missing/ incomplete/ Invalid "from" date(s) of service.	**322**	Date of surgery is missing or invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**388**	Missing/invalid requesting provider – provider id or license number.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**476**	Lab services must be billed with combination code. See CPT.
125	Payment adjusted due o a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**MA34**	Missing/ incomplete/invalid number of coinsurance days during the billing period.	**478**	This claim does not contain required data to determine Medicaid liability for coinsurance days/lifetime.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
					reserve days.
125	Payment adjusted due o a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**MA34**	Missing/ incomplete/invalid number of coinsurance days during the billing period.	**487**	This claim does not contain required data to determine Medicaid liability for coinsurance/lifeti me reserve days.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**612**	Changing the response from 3 (invalid) to a blank.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N39**	Procedure code is not compatible with tooth number/letter.	**637**	Claims history shows tooth has been extracted.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**742**	Lab services must be billed with combination code. See cpt.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M83**	Service is not covered unless the patient is classified as at high risk.	**743**	Provider may not bill for newborn resuscitation unless life threatening.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**758**	Chemistry profiles must be billed using one multichannel test code.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**900**	Prescription number cannot be spaces or zeroes.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M53**	Missing/ incomplete/Invalid days or units of service	**901**	The quantity dispensed is missing or not numeric.
125	Payment adjusted due to a submission/billing error(s). Additional information is	**N57**	Missing/incomplete/ invalid prescribing date.	**904**	Date prescribed is invalid.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
	supplied using the remittance advice remarks codes whenever appropriate.				
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**905**	Emergency indicator is invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N57**	Missing/incomplete/ invalid prescribing date.	**908**	Dispense date is earlier than date prescribed.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**909**	The claim net charge is missing, calculated incorrectly or equal to zero.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**910**	EPSDT indicator is invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**912**	Detail dos not within the header DOS.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**913**	Claim cannot be paid due to errors at the detail.
25	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N46**	Missing/incomplete/ invalid admission hour.	**914**	The admission hour field must be numeric and between 00 and 23.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**915**	Employment indicator invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N50**	Missing incomplete/invalid discharge information.	**916**	Discharge hour is invalid; must be between 00 and 23.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**MA33**	Missing/incomplete/invalid number of noncovered days during the billing period.	**917**	Non-covered days are invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M45**	Missing/incomplete/ invalid occurrence code(s).	**918**	Occurrence code 1, 2, 3, 4 or 5 is not between from and to dates of service.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M45**	Missing/Incomplete/ invalid occurrence code(s).	**919**	The occurrence dates are invalid or a future date.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M45**	Missing/Incomplete/ invalid occurrence code(s).	**920**	Occurrence date 1, 2, 3, 4, or 5 is not between from and to dos.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M44**	Missing/incomplete/invalid condition code.	**921**	Condition codes are invalid. Refer to Alabama Medicaid guidelines.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**922**	Payment denied because third party amount is greater than the total submitted charge, missing or is not numeric.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**923**	Surgery, occurrence, and/or condition count is missing or invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M46**	Missing/incomplete/invalid occurrence span code(s).	**924**	Occurrence span code is invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**M46**	Missing/incomplete/invalid occurrence span code(s).	**925**	Occurrence span date is invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the			**926**	Accident related indicator is invalid. Medical billing.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
	remittance advice remarks codes whenever appropriate.				authorization form (XIX-TPD-1-76) is required for this claim.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**929**	Detail count missing or invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**930**	Dispense as written code invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**950**	DUR conflict, intervention, or outcome codes are invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**951**	Previous DUR alerted claim cannot be found.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N22**	This procedure code was added/changed because it more accurately describes the services rendered.	**954**	The claim has been adjusted to reflect a change in codes as billed.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**958**	This claim has been adjusted to reflect a change in the original amount billed.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**962**	Other-If you have any questions resulting from this adjustment, please contact our Correspondence /Inquiry Unit.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**968**	Claim adjusted to reflect a rate change.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks			**989**	This claim was recouped per your request.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
	codes whenever appropriate.				
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**990**	This claim has been adjusted to reflect a change in the dispensed as written value code.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**993**	Employment indicator invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N61**	Rebill services on separate claims.	**995**	Claim recouped. Provider must resubmit claims on separate claims in order for services to be considered for payment by Medicaid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.			**997**	Claim contains 15 or more error and therefore can not be processed as billed.
132	Prearranged demonstration project adjustment.	**N10**	Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor	**953**	Special adjustments - please refer to our mini message included in your explanation of payment.
133	The disposition of this claim/service is pending further review.			**325**	This service is pending approval and code assignment, contact EDS for information.
133	The disposition of this claim/service is pending further review.			**425**	Provider eligibility determination is being made. Please do not rebill.
133	The disposition of this claim/service is pending further review			**426**	Claim in process due to review of claim history. Please do not resubmit.
133	The disposition of this claim/service is pending further review.			**427**	Claim still in process. Please do not rebill.
133	The disposition of this claim/service is pending further review.			**430**	Please do not rebill. Claim is being reviewed by medical consultant.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
140	Patient/Insured health identification number and name do not match.			**259**	The recipient name on this claim does not match the name on file for Medicaid number shown.
140	Patient/Insured health identification number and name do not match.			**393**	Recipient's Medicaid number does not match the Medicaid number on the pa file.
141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.	**N61**	Rebill services on separate claims.	**82**	Dates exceed SOBRA/QMB eligibility. Obtain SOBRA/QMB dates and split bill.
141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.	**N61**	Rebill services on separate claims.	**93**	Claim spans more than one managed care plan. Obtain managed care data and split bill.
141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.	**N61**	Rebill services on separate claims.	**255**	Records show this recipient is partially ineligible for Medicaid for header date(s) of service.
141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.	**N61**	Rebill services on separate claims.	**263**	Records show this recipient is partially ineligible for Medicaid for detail date(s) of service.
141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.	**N61**	Rebill services on separate claims.	**317**	Katrina/Rita claim spans plan codes/eligibility periods.
142	Claim adjusted by the monthly Medicaid patient liability amount.			**371**	Recipient resources exceed the Medicaid allowed amount.
142	Claim adjusted by the monthly Medicaid patient liability amount.			**372**	Patient resources exceed the Medicaid allowed amount.
142	Claim adjusted by the monthly Medicaid patient liability amount.			**964**	This claim has been adjusted to reflect correct recipient resources.
147	Provider contracted/ negotiated rate expired or not on file.	**N65**	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/ provider.	**12**	No level III base value for anesthesia for dates of service billed.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
147	Provider contracted/negotiated rate expired or not on file.	**N65**	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	**72**	Provider/procedure code not on level I pricing file.
151	Payment adjusted because the payer deems the information submitted does not support this many services.			**911**	Refill number is missing, greater than five or is greater than the refill.
154	Payment adjusted because the payer deems the information submitted does not support this day's supply.			**903**	Days supply greater than authorized days or invalid.
167	This (these) diagnosis(es) is (are) not covered.	**M76**	Missing/incomplete/ Invalid diagnosis or condition.	**39**	Services are not covered for indicated diagnosis.
167	This (these) diagnosis(es) is (are) not covered.	**M76**	Missing/incomplete/ Invalid diagnosis or condition.	**76**	The diagnosis code billed is not covered for MHSP.
167	This (these) diagnosis(es) is (are) not covered.			**190**	Primary diagnosis code is invalid or noncovered.
167	This (these) diagnosis(es) is (are) not covered.	**M64**	Missing/incomplete/ Invalid other diagnosis.	**191**	Secondary diagnosis code is invalid or non-covered.
167	This (these) diagnosis(es) is (are) not covered.			**200**	Primary diagnosis code not covered.
167	This (these) diagnosis(es) is (are) not covered.	**M64**	Missing/incomplete/ Invalid other diagnosis	**201**	Other diagnosis code not covered.
167	This (these) diagnosis(es) is (are) not covered.			**205**	Detail diagnosis is not on file.
172	Payment is adjusted when performed/billed by a provider of this specialty.	**M76**	Missing/incomplete/ invalid diagnosis or condition.	**189**	Diagnosis invalid for provider specialty.
177	Payment denied because the patient has not met the required eligibility requirements.			**429**	Recipient eligibility determination is being made. Please do not rebill.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
183	The referring provider is not eligible to refer the service billed.			**48**	Referring provider must be a valid EPSDT screening provider. Contact EDS for a screening provider listing.
184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	**N31**	Missing/incomplete/ Invalid prescribing provider identifier.	**907**	The prescribing provider's license number is missing or invalid.
185	The rendering provider is not eligible to perform the service billed.			**50**	EPSDT screenings may only be billed by an EPSDT screening provider. Contact the provider enrollment unit at EDS.
185	The rendering provider is not eligible to perform the service billed.			**65**	Procedure billed is invalid for provider.
185	The rendering provider is not eligible to perform the service billed.			**74**	Type 30 for county health department is limited to providing services for recipients under 21. (EPSDT only provider billed non-EPSDT referral claim).
185	The rendering provider is not eligible to perform the service billed.	**N95**	This provider type/ provider specialty may not bill this service.	**77**	PC invalid for this provider number.
185	The rendering provider is not eligible to perform the service billed.	**N95**	This provider type/ provider specialty may not bill this service.	**85**	Maternity care provider restricted to maternity service.
185	The rendering provider is not eligible to perform the service billed.			**221**	Enrollment file indicates provider is deceased.
185	The rendering provider is not eligible to perform the service billed.			**223**	Provider is suspended from the Medicaid program.
185	The rendering provider is not eligible to perform the service billed.			**227**	Provider is enrolled in the Medicaid program for crossover claims only.

Claim Adj Reason Code	Claim Adjustment Reason Code Description	Remittance Remarks Code	Remittance Advice Remark Codes Description	EOB Code	EOB Description
185	The rendering provider is not eligible to perform the service billed.			**239**	Provider eligible for only QMB recipients and EPSDT referrals.
185	The rendering provider is not eligible to perform the service billed.			**258**	Medicaid has restricted the services of this recipient to a specific provider and/or specific drugs.
185	The rendering provider is not eligible to perform the service billed.			**300**	Provider not enrolled for VFC program.

J.2 Adjusted Claim Codes

Claim Adj Reason Code	Claim Adj Reason Code Description	Remittance Advice Remark Codes Description	EOB Code	EOB Description
B20	Payment adjusted because procedure/service was partially or fully furnished by another provider.	**N10** Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor	957	This payment has been recouped to enable payment to the correct provider.
B12	Services not documented in patients' medical record.		965	Services not documented in patients' medical record.
1	Deductible amount		961	This claim has been adjusted to reflect a change in coinsurance and/or deductible.
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.		980	Claim adjusted to add/delete modifier.
18	Duplicate claim/service.		970	This claim has been recouped/adjusted due to a duplicate payment.
22	Payment adjusted because this care may be covered by another payer per coordination of benefits.		991	Recipient has become retroactively eligible for Medicare for billed dates of service billed. File Medicare.
23	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments.		960	This claim has been adjusted to reflect payment by other insurance.
58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.		956	This claim has been adjusted to reflect a change in the type of service.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.		955	The claim has been adjusted to reflect changes in the number of units billed and paid.
119	Benefit maximum for this time period or occurrence has been reached.		983	Claim adjusted/recouped because physician office visits have been exceeded for calendar year.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.	**N22** This procedure code was added/changed because it more accurately describes the services rendered.	954	The claim has been adjusted to reflect a change in codes as billed.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.		958	This claim has been adjusted to reflect a change in the original amount billed.

Claim Adj Reason Code	Claim Adj Reason Code Description	Remittance Advice Remark Codes Description	EOB Code	EOB Description
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.		962	Other-If you have any questions resulting from this adjustment, please contact our Correspondence/Inquiry Unit.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.		968	Claim adjusted to reflect a rate change.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.		989	This claim was recouped per your request.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.		990	This claim has been adjusted to reflect a change in the dispensed as written value code.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.		993	Employment indicator invalid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.		995	Claim recouped. Provider must resubmit claims on separate claims in order for services to be considered for payment by Medicaid.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.		997	Claim contains 15 or more error and therefore can not be processed as billed.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.		Z12	Invalid MMIS data
132	Prearranged demonstration project adjustment.	**N10** Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor	953	Special adjustments - please refer to our mini-message
142	Claim adjusted by the monthly Medicaid patient liability amount.		964	Claim adjusted by the monthly Medicaid patient liability amount.

J.3 Electronic Up-Front Rejections

Rejection Code	Description
0010	HEADER from date of service invalid
0011	HEADER from date of service cannot be a future date
0020	Admission date is invalid
0021	The Admit date cannot be in the future
0022	The Admit date cannot be Greater than the Billing From date of service
0030	Header TO date of service invalid
0031	Header TO date of service cannot be a future date
0032	Header to DOS cannot be prior to the from DOS
0051	Surgery date 1 not between admit and to DOS
0052	Surgery date 2 not between admit and to DOS
0053	Surgery date 3 not between admit and to DOS
0054	Surgery date 4 not between admit and to DOS
0055	Surgery date 5 not between admit and to DOS
0060	The Non covered charge is numeric and positive but greater than 0 and is >= to covered charge
0061	Non covered charge is not numeric
0062	Non covered charge is negative
0063	Non covered charge exceeds maximum size allowed by MMIS
0064	Non covered charge exceeds maximum size allowed by MMIS and is negative
0070	Number days / billing period disagree
0071	Non covered days is not numeric
0072	Non covered days exceeds 366 days
0073	Calculated days billed exceeds 366 days
0080	Header To DOS is beyond the 365-day filing limit
0081	Header To DOS is beyond the 120-day filing limit
0082	Header To DOS is beyond the PHP filing limit
0083	Previous RA Date is invalid or beyond the 365-day filing limit
0130	Neonatal revenue code/diagnosis code mismatch
0140	Valid modifier is required for billed procedure
0150	Transportation service must be medically necessary
0170	Recipient is not eligible
0180	Home health / therapy services cannot be billed together
0190	HIV counseling code billed without HIV
0220	Days covered invalid
0221	Covered days is negative
0222	Covered days is numeric but exceeds 366
0230	Organ transplants require prior approval
0250	Unborn recipient eligible only for infant services
0260	EPSDT referred therapy services restricted to POS 11 or 99
0271	Modifier 1 valid only on crossover claims
0272	Modifier 2 valid only on crossover claims
0273	Modifier 3 valid only on crossover claims

Rejection Code	Description
0274	Modifier 4 valid only on crossover claims
0280	Header paid amount exceeds the specified dollar limit
0290	Type of bill invalid
0300	Units are not numeric
0301	Claim type is not IP, IX, LT or LX and units are negative
0302	Units are numeric but MMIS size exceeded
0303	Units are numeric, but negative, and the MMIS size is exceeded
0304	Units not equal to 1
0305	Fractional units not allowed
0310	Detail rate submitted is invalid
0320	Modifier 1 not effective for DOS
0321	Modifier 2 not effective for DOS
0322	Modifier 3 not effective for DOS
0323	Modifier 4 not effective for DOS
0330	Invalid revenue code for recipient over one year old
0331	Invalid revenue code for recipient one year old or younger
0340	Cataract services require proper modifier to be billed
0360	Submitted rate, units, and detail charge do not balance
0370	Nursery days must not exceed 10 under mother's number
0371	Nursery days/revenue codes invalid
0380	Pricing file indicates zero price – contact EDS
0390	Services not covered for indicated diagnosis
0400	QMB/EPSDT service limited to QMB/EPSDT related claim
0410	Only fifty lines allowed per claim
0420	EPSDT referred services restricted to recipients over 21
0430	Billed amount is not greater than zero
0431	Billed amount is not numeric
0432	Billed amount exceeds maximum MMIS size
0433	Billed amount exceeds maximum size allowed by MMIS and is negative
0440	Medicare paid amount is Missing or Invalid
0450	Medicare Allowed amount is Missing or Invalid
0451	Medicare allowed amount must be greater than zero
0460	Medicare Total Bill amount is Missing or Invalid
0470	Co-insurance amount is invalid
0471	Co-insurance amount does not balance
0480	Referring physician required on EPSDT referral
0481	Referring physician not on file
0482	Referring physician must be an EPSDT screening provider
0500	EPSDT screenings limited to EPSDT screening providers
0510	Patient status invalid
0520	Medicare header allow amount not equal sum of detail Medicare allow amounts
0530	Net billed amount not equal to sum of detail charges less TPL amt
0531	Sum of detail charges exceeds maximum allowed
0540	Sum Of Detail Non Cov Chg Not Equal Header Non Covered Charge
0550	Billed amount not equal to sum of the detail charge amounts
0551	Sum of detail non-covered charges exceeds maximum allowed

Rejection Code	Description
0560	Medicare header Paid amount not equal sum of detail Medicare Paid amounts
0580	Service for Maternity Waiver/Care recipient must be billed with Global Service Fee
0590	Maternity Waiver/Care Claim must be billed by Contract Provider
0600	Maternity Waiver/Contract Provider can only bill Maternity Waiver/Care claims
0610	Injectible/non-injectible procedures cannot be billed together for EPSDT County Health providers
0630	Recipient has no county code on eligibility file
0650	Procedure code billed is invalid for the provider
0660	Admit type is invalid as billed
0670	Service for Maternity Waiver/Care Recipient Requires PA
0680	Hospice coinsurance/deductible invalid
0690	Dental sealants not payable for this recipient
0691	Dental sealant not payable for tooth number specified
0710	Invalid place of service for FQHC provider
0720	Pcode not on Level 1 for the provider and date of service
0721	Pcode no longer covered for provider
0730	Family planning service not covered for this recipient
0731	Family planning srvc (surg code 1) not covered for this recipient
0732	Family planning srvc (surg code 2) not covered for this recipient
0733	Family planning srvc (surg code 3) not covered for this recipient
0734	Family planning srvc (surg code 4) not covered for this recipient
0735	Family planning srvc (surg code 5) not covered for this recipient
0740	EPSDT only provider must bill EPSDT referral
0750	Procedure not on Level 1 for the provider and date of service
0751	Procedure no longer covered for provider
0760	Diagnosis code billed is not covered for MHSP
0770	VFC Provider may only bill VFC procedures
0780	Critical care procedures cannot span more than two days
0790	Procedure code not valid for Renal Dialysis Facility
0810	Procedure code cannot be billed with type of bill 141
0820	Service dates span eligibility change
0840	Service is not covered for a SOBRA eligible recipient
0860	Recipient not eligible for targeted case management
0870	Different TCM procedure codes must be billed on separate claims
0880	CLIA number not on file
0881	CLIA number invalid for DOS
0882	Provider certified for CLIA PPMP or waiver pcodes only
0883	Provider certified for CLIA waivered pcodes only
0890	Medicare Paid amount equal 100%
0900	Global delivery procedure code cannot be span dated
0910	Medicare paid date invalid
0911	Medicare paid date cannot be a future date
0920	TPL adjudication date invalid
0921	TPL adjudication date cannot be a future date
0930	Details covered by more than one plan within managed care program, split bill

Rejection Code	Description
0931	Not all details covered by same managed care program, split bill
0932	Recipient partially covered by managed care plan, split bill
0934	Services partially covered by managed care plan, split bill
0940	Coinsurance not numeric or > 366
0941	Coinsurance days are > max
0950	LTR days not numeric or > 366
0951	LTR days are zero or > max
0960	Coinsurance and/or Lifetime Reserve days are invalid.
0970	Rev code and pcode combo not valid
0971	Pcode and rev code combo not valid
0980	Service not covered by Medicaid
0981	Revenue code not covered by Medicaid
0990	Medicare Deductible amount is invalid
1000	Detail from date of service invalid
1001	Detail from date of service cannot be a future date
1010	Detail TO date of service invalid
1011	Detail TO date of service cannot be a future date
1012	Detail to DOS cannot be prior to the from DOS
1020	Detail DOS beyond the 365-day filing limit
1021	Detail DOS beyond the 120-day filing limit
1022	Detail DOS beyond the 180-day filing limit
1030	Therapy code payable only with therapeutic treatment
1040	ER & critical care codes one per claim
1050	Service included in revenue code 450 facility fee
1060	Anesthesia claims require referring provider
1070	Patient 1st claim requires PMP provider on claim
1090	Observation code must be billed with facility fee
1100	Invalid deductible amount for skilled nursing facility
1110	Inpatient/Outpatient Non-Covered Rev Codes For EPSDT Referred Claims
1130	Procedure not covered for an Ambulatory Surgical Center
1140	Service non-payable for recipient < six months of age
1231	Oral cavity designation code invalid
1236	Oral cavity designation code invalid
1237	Oral cavity designation code invalid
1238	Oral cavity designation code invalid
1239	Oral cavity designation code invalid
1240	More than one tooth number per claim detail
1260	Tooth surface is required for procedure
1261	Tooth surface is invalid
1270	Invalid tooth for procedure
1280	Tooth number is required for procedure
1281	Tooth number is invalid
1290	Procedure code is not covered for primary teeth, third molars or supernumerary.
1300	Invalid claim type for Plan First Program
1310	Service is only covered under the Plan First Program

Rejection Code	Description
1320	Birth control pills must be received from a physician for the Plan First Program
1330	Plan First Recipient must be seen by a Plan First Network Provider
1340	Plan First Recipient is only eligible for Plan First Services
1350	Procedure code specific to Technology Assisted Waiver only
1360	Place of service code is invalid
1440	Place of service is not valid for provider type
1451	First modifier is invalid
1452	Second modifier is invalid
1453	Third modifier is invalid
1454	Fourth modifier is invalid
1460	Procedure code is inappropriate for this provider type
1471	First modifier is invalid for procedure code billed
1472	Second modifier is invalid for procedure code billed
1473	Third modifier is invalid for procedure code billed
1474	Fourth modifier is invalid for procedure code billed
1480	Place of service code is invalid for procedure
1490	Procedure code is inappropriate for the recipient's age
1491	Revenue code is inappropriate for the recipient's age
1499	NDC is inappropriate for the recipient's age
1500	Procedure code is inappropriate for the recipient's Sex
1501	Revenue code is inappropriate for the recipient's Sex
1509	NDC is inappropriate for the recipient's Sex
1510	Procedure code not found for DOS
1511	Revenue code not found for DOS
1515	Service dates span procedure code effective date segments
1516	Service dates span revenue code effective date segments
1519	NDC is invalid for DOS
1520	Service code missing or invalid
1521	Revenue code missing or invalid
1528	Invalid qualifier list code
1529	NDC is not on file
1530	Detail diagnosis is inappropriate for the procedure billed
1531	First diagnosis is inappropriate for the procedure
1532	Second diagnosis is inappropriate for the procedure
1533	Third diagnosis is inappropriate for the procedure
1534	Fourth diagnosis is inappropriate for the procedure
1535	Fifth diagnosis is inappropriate for the procedure
1536	Sixth diagnosis is inappropriate for the procedure
1537	Seventh diagnosis is inappropriate for the procedure
1538	Eighth diagnosis is inappropriate for the procedure
1540	Procedure code is inappropriate for this provider specialty
1550	Procedure code invalid for claim type
1551	Revenue code invalid for claim type
1580	Emergency services recipient is only eligible for emergency services
1590	Invalid claim type for emergency services program

Rejection Code	Description
1610	Procedure invalid for service performed
1611	Revenue code invalid or not on file
1620	Units Billed Exceed Max Allowed Per Day
1640	Header days and detail days disagree
1641	No accommodation revenue codes billed
1740	Diagnosis requires accident indicator
1750	Operation or delivery requires surgical procedure code
1780	Procedure code must be billed with chemotherapy
1830	Date of service is before the recipient's date of birth
1840	Services not covered for recipient 22 or older
1850	Procedure not covered at POS for provider
1890	Diagnosis inappropriate for provider specialty
1900	Primary header diagnosis is invalid
1912	Header diagnosis 2 is invalid
1913	Header diagnosis 3 is invalid
1914	Header diagnosis 4 is invalid
1915	Header diagnosis 5 is invalid
1916	Header diagnosis 6 is invalid
1917	Header diagnosis 7 is invalid
1918	Header diagnosis 8 is invalid
1940	Primary diagnosis is not appropriate for recipient age
1952	Diagnosis 2 is not appropriate for recipient age
1953	Diagnosis 3 is not appropriate for recipient age
1954	Diagnosis 4 is not appropriate for recipient age
1955	Diagnosis 5 is not appropriate for recipient age
1956	Diagnosis 6 is not appropriate for recipient age
1957	Diagnosis 7 is not appropriate for recipient age
1958	Diagnosis 8 is not appropriate for recipient age
1960	Primary diagnosis is not appropriate for recipient sex
1972	Header diagnosis 2 is not appropriate for recipient sex
1973	Header diagnosis 3 is not appropriate for recipient sex
1974	Header diagnosis 4 is not appropriate for recipient sex
1975	Header diagnosis 5 is not appropriate for recipient sex
1976	Header diagnosis 6 is not appropriate for recipient sex
1977	Header diagnosis 7 is not appropriate for recipient sex
1978	Header diagnosis 8 is not appropriate for recipient sex
1980	Primary diagnosis must be billed at highest subdivision
1992	Diagnosis 2 must be billed at highest subdivision
1993	Diagnosis 3 must be billed at highest subdivision
1994	Diagnosis 4 must be billed at highest subdivision
1995	Diagnosis 5 must be billed at highest subdivision
1996	Diagnosis 6 must be billed at highest subdivision
1997	Diagnosis 7 must be billed at highest subdivision
1998	Diagnosis 8 must be billed at highest subdivision
2000	Primary diagnosis not covered

Rejection Code	Description
2012	Diagnosis 2 not covered
2013	Diagnosis 3 not covered
2014	Diagnosis 4 not covered
2015	Diagnosis 5 not covered
2016	Diagnosis 6 not covered
2017	Diagnosis 7 not covered
2018	Diagnosis 8 not covered
2051	Detail diagnosis 1 invalid
2052	Detail diagnosis 2 invalid
2053	Detail diagnosis 3 invalid
2054	Detail diagnosis 4 invalid
2190	Billing provider identified for purge. Call EDS at 1(888) 223-3630.
2200	Provider does not have authorization to bill electronically
2210	Provider is deceased on DOS being billed
2220	Provider address on file is not current – mail returned
2230	Provider suspended from the Medicaid program
2240	Provider has been canceled
2250	Provider rate not found for the date of service billed
2260	Claim type is not valid for this provider
2270	Provider not eligible for Medicaid
2280	Provider is ineligible on DOS being billed
2290	Provider number is invalid
2291	Provider number is not on file
2292	Provider name and number disagree
2293	Provider specialty not found for date of service submitted
2300	Attending Physician's License Number is Missing
2350	Billing provider must be group provider number
2360	Performing provider cannot be group provider number
2370	Provider number is Not on File
2371	Provider Action reason code segment is in cancelled status
2372	Provider Action reason code segment is in deceased status
2373	Performing provider number cannot be spaced or zeros
2380	Performing provider not associated with the group
2390	Provider eligible for only QMB recipients
2480	Eligible for Medicare only-no Medicaid or QMB benefits
2500	Recipient number not on file
2501	Recipient number missing or zeroes
2502	Recipient on Xref but not on Base-Call EDS
2510	Recipient has an unusable record - contact EDS
2540	Recipient is totally ineligible for header DOS
2550	Recipient is partially ineligible for header DOS
2560	Recipient number missing or invalid
2570	Birth date is invalid
2580	Recipient is locked in to a specific pharmacy/no pharmacy selected
2581	Recipient is locked in to a different provider

Rejection Code	Description
2582	Recipient is locked out of specific drugs
2583	Recipient is locked out of controlled substances
2590	Recipient's ID is invalid for the recipient's first name
2591	Recipient name is required
2620	Recipient is totally ineligible for detail DOS
2630	Recipient is partially ineligible for detail DOS
2640	Recipient ineligible for geriatric or inpatient psychiatric services
2670	Census data not on file for provider for the previous month
2700	Recipient is not on the LTC eligibility file for the date of service
2720	Provider does not match provider on LTC file for recipient
2760	Recipient ineligible for waivered service
2761	Recipient ineligible for waivered services from this provider
2762	Provider not eligible for waivered services
2790	Recipient has Medicare HMO coverage
2800	Recipient has other medical coverage – file third party carrier first
2820	Recipient is Medicare suspect
2831	Type of Service Not Valid for Modifier 1
2832	Type of Service Not Valid for Modifier 2
2833	Type of Service Not Valid for Modifier 3
2834	Type of Service Not Valid for Modifier 4
2950	Production provider cannot bill claims for test recipient
2951	Test provider cannot bill claims for production recipient
3000	Vaccine procedure only payable under vaccines for children program
3040	Surgery provider number is invalid
3100	Detail charge amount is zero
3101	Detail charge amount is not numeric
3102	Detail charge amount is negative
3103	Detail charge amount exceeds maximum size allowed by MMIS
3104	Detail charge amount exceeds maximum size allowed by MMIS and is negative
3109	Detail charge amount is unsigned
3130	Admitting diagnosis is invalid
3140	From DOS and to DOS must be within the same month
3150	From DOS and t-To DOS must not span the calendar year
3151	From DOS and To DOS must not span the fiscal year
3160	Date range cannot exceed 90 days
3221	Surgery date 1 required if surgery procedure code 1 present
3222	Surgery date 2 required if surgery procedure code 2 present
3223	Surgery date 3 required if surgery procedure code 3 present
3224	Surgery date 4 required if surgery procedure code 4 present
3225	Surgery date 5 required if surgery procedure code 5 present
3229	Operating physician required if surgery procedure(s)are present
3230	Invalid claim submission reason code
3231	Original ICN is not valid on an original claim
3232	Must supply original ICN on an adjustment request
3235	Invalid claim submission code
3236	Must supply original ICN on an adjustment request

Rejection Code	Description
3237	Supp pay indicator must be equal R
3750	Product is not preferred
3820	The original ICN cannot be adjusted
3821	Original claim status invalid for adjustment
3822	Adjustment of original claim already in progress
3823	Original provider and/or recipient not matched
3829	Invalid MMIS adjustment
3840	Service code home health but Prog blank
3850	Duplicate PA request
3860	First PA detail has certification type 'I', but current detail is not certification type 'I'
3861	First PA detail is not certification type 'I', but current detail is certification type "I"
3862	First PA detail is not certification type 'I', and current detail is not certification type 'I', but the prior PA number on each do not agree
3870	Neither requested dollars or requested units are supplied
3871	Requested dollars are not numeric
3872	Requested dollars are negative
3873	Requested dollars are numeric but MMIS size exceeded
3874	Requested dollars are numeric, but negative, and the MMIS size is exceeded
3875	Requested units are not numeric
3876	Requested units are negative
3877	Requested units are numeric but MMIS size exceeded
3878	Requested units are numeric, but negative, and the MMIS size is exceeded
3881	Provider ID is zeros or spaces
3882	Provider not found on provider base or provider license
3890	Prior authorization number is not on file
3891	Prior authorization number is not numeric
3892	Previous prior authorization number is not approved
3900	Claim and prior authorization provider do not match
3901	Claim and prior authorization prescriber do not match
3910	Prior authorization required dates overlap dates of service on claim
3920	Prior authorization units are exhausted
3930	Recipient ID does not match the PA Recipient ID
3940	PA denied, NDC req PA
3941	Non-preferred product required PA
3943	PRAHOST open error
3944	PRAHOST read error
3945	PA req/resp mismatch
3946	PA resp data invalid
3947	PA req timeout – HID

Rejection Code	Description
3948	PA resp format error
3949	DASS RC not equal 0
3970	Active PA detail not found for PA number billed
3971	PA number does not match dates of service billed
3980	Allowed charges exceed authorized dollars on PA file
3990	Prior authorization required
3991	Prior authorization required for inpatient pysch related services
3992	Prior authorization required for certain transportation services
3993	Prior authorization required for place of service billed
3994	Prior authorization required for personal care/private duty nursing
3995	Private duty nursing services require PA and a EPSDT screening referral
3996	Inpatient Svcs for Plan First Recipients Limited to PA'd Tubal Ligations
3999	Prior authorization required
4200	Quantity dispensed exceeds units/day PA (PA begin date)
4900	Pharmacy claim – exact dup
4910	Pharmacy claim – suspect dup of history claim
4911	Pharmacy claim – suspect dup of another detail
4920	Monthly scrip limit exceeded (min/max)
4930	Duplicate RX code, refill number, and NDC
9000	Prescription number is missing or invalid
9010	Drug quantity cannot be zero
9011	Drug quantity must be numeric
9012	Drug quantity cannot exceed 99,999.999
9031	Days supply equal to zero
9032	Days supply must be numeric
9033	Days supply limit exceeded
9040	Date prescribed is invalid or missing
9070	Prescribing provider's license number is not on file
9071	Prescribing provider's license number is inactive
9080	Date dispensed is prior to date prescribed
9110	Refill number exceeds refills allowed for NDC
9111	Refill indicator not numeric
9270	OTC drug not covered for LTC recipient
9300	Medical necessity (DAW) indicator is invalid
9301	Medical necessity (DAW) indicator is not numeric
9310	M/I Service Provider ID Qualifier
9320	M/I Insurance Segment
9330	M/I Claim Segment
9340	Product/Service not covered
9350	M/I Product/Service ID Qualifier
9360	M/I Prescriber Segment
9370	M/I Prescriber ID Qualifier
9380	M/I Pricing Segment
9390	M/I Other Payer Amount Paid Qualifier
9400	M/I Segment Identification

Rejection Code	Description
9410	Criteria for pregnancy copay exemption not met
9500	DUR conflict code is invalid
9501	DUR intervention code invalid
9502	DUR outcome code invalid
9510	Previous DUR alerted claim cannot be found
9511	Claim to cancel cannot be found
9520	Previously alerted claim cannot be overridden – corresponding alert not found
9521	Previously alerted claim cannot be overridden – outcome indicates no change, DUR fields changed
9522	Previously alerted claim cannot be overridden – outcome indicates change, DUR fields not changed
9523	Previously alerted claim cannot be overridden – alert requires a PA override
A030	Max quantity exceeded for 30-day period
Z110	Detail DOS not within the header DOS
Z111	Calculated TDOS not within header DOS
Z140	Admission hour is invalid
Z141	Admission minute is invalid
Z160	Discharge hour is invalid
Z161	Discharge minute is invalid
Z170	Non-Covered days are invalid
Z171	Non-Covered days exceeds 366 days
Z191	Occurrence Date 1 is invalid
Z192	Occurrence Date 2 is invalid
Z193	Occurrence Date 3 is invalid
Z194	Occurrence Date 4 is invalid
Z195	Occurrence Date 5 is invalid
Z211	Condition code 1 is invalid
Z212	Condition code 2 is invalid
Z213	Condition code 3 is invalid
Z214	Condition code 4 is invalid
Z215	Condition code 5 is invalid
Z220	Invalid TPL indicator
Z221	TPL amount must be numeric
Z225	Third party amount (TPL) exceeds total billed
Z229	Other coverage amount is unsigned
Z230	Surgery count missing or invalid
Z231	Occurrence count missing or invalid
Z233	Diagnosis count missing or invalid
Z310	Social Security number not found
Z311	No recipient found that matches request
Z312	Multiple recipients found, resubmit with additional and/or corrected information, or use recipient id
Z313	Last name does not match SSN
Z314	First name does not match SSN
Z315	Middle initial does not match SSN
Z316	Date of birth does not match SSN

Rejection Code	Description
Z800	Claim has already been reversed.
Z801	RX number not found on claim
Z803	RX number is not numeric.
Z804	Non-matched NDC number
Z810	Invalid ICN
Z811	ICN not found on claim file.
Z812	Invalid ICN for claim type.
Z813	Claim has already been reversed.
Z820	Recipient id/claim record mismatch
Z830	Provider id/claim record mismatch
Z840	Claim can only be reversed the same day as submitted
Z980	Non-covered charge is invalid (Header)
Z981	Net amount is invalid (Header)
Z982	Error Count is invalid (Header)
Z983	Location count is invalid (Header)
Z984	Location detail number is invalid (Location – Header)
Z985	Location date is invalid (Location – Header)
Z986	Location age is invalid (Location – Header)
Z987	Detail number is invalid (Detail)
Z988	Manual amount is invalid (Detail)
Z990	Detail count missing or invalid

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